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Supreme Court of the United States

OCTOBER TERM, 1976

No. 75-1691

PAUL I. GUEST, ET AL., APPELLANTS

v.

F. EMMETT FITZPATRICK, ET AL.

No. 75-1698

THE WILLIAMSPORT HOSPITAL, ET AL., APPELLANTS

v.

F. EMMETT FITZPATRICK, ET AL.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

BRIEF OF APPELLEES

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Counterstatement of Questions Presented

[Questions in Nos. 75-1691 and 75-1698]

The following three questions are presented by the appeals in both No. 75-1691 and No. 75-1698:

1. May a State, consistent with the Due Process and Contract Clauses of the Constitution of the United States, prescribe as temporary hospital service charges or rates, for a period not exceeding 10 months (13 months on a transitional basis), the rates previously in force, where at the expiration of such temporary rate period each affected hospital may exercise an unrestricted right to fix its rates for hospital services thereafter furnished at whatever level it may deem appropriate to recoup any deficiency in income caused by the action of the State in fixing temporary rates?

2. Assuming *arguendo* that notwithstanding the ability to effect recoupment at the end of the temporary rate period, a State must insure that any temporary hospital service rate level fixed does not fall below the zone of reasonableness and become confiscatory, is a cost-of-service formula constitutionally permissible which expressly covers all direct costs of the services furnished and a proportionate portion of joint costs (including depreciation of capital assets), but which excludes subsidization of indigent patient expenses, accumulations for the future purchase of equipment, research costs and other expenditures not necessary to

the furnishing of the hospital services for which the challenged temporary rates have been established?

3. Was the District Court correct in concluding that the issue of alleged confiscation by a statutory temporary rate formula could be resolved by an examination of the cost-of-service nature of the formula itself, without the need for a *de novo* trial in the nature of a public utility rate case?

[Questions in No. 75-1691 only]

The following two questions are presented by the appeal in No. 75-1691:

4. When a group of hospitals have repeatedly followed the practice during inter-contract intervals of treating the financial arrangements which they make with discharged Blue Cross subscribers as provisional and subject to complete recharacterization (both as to identity of parties and basis of payment) upon the execution of a succeeding Blue Cross-hospital contract, are such arrangements sufficiently fluid to permit a State constitutionally to impose price regulation thereon?

5. Assuming *arguendo* that the Contract and Due Process Clauses are applicable to price regulation by a State of the inter-contract interval arrangements between a hospital and Blue Cross subscribers, may a State extend the reach of its 10 month (13 month) temporary rate procedures retroactively for varying

periods of up to 11½ additional months so as to close a newly-opened gap in a 38-year old scheme of regulation and eliminate invidious discrimination among Blue Cross subscribers whose subscription agreements terminate at different times during the inter-contract interval?

[All questions to be answered in the Affirmative]

Counterstatement of the Case

The Blue Cross-Subscriber Contract. As indicated in the record (A.77-78 ¶¶ 3-4)[1], Blue Cross plans were established by the hospital industry itself as a mechanism to pre-pay the costs of hospital service. See also *Travelers Ins. Co.* v. *Blue Cross of Western Pa.*, 361 F. Supp. 774, 779 (W.D. Pa. 1972).

A potential hospital patient enters into a subscription contract with a hospital plan corporation (hereinafter a "Blue Cross Plan" or a "Plan"). Under the typical subscription agreement the Blue Cross Plan agrees to provide one of two alternative types of benefits.

Under the more usual arrangement, the Plan will obtain hospital services for the subscriber in a so-called "member hospital". In some cases the subscriber must pay a relatively small portion of the hospital bill as coinsurance. In other cases the full hospital service is provided by the Plan, and no payment is made by the subscriber in connection with a spell of hospitalization. The benefit under this alternative is referred to as a "service benefit" (A.80-88 ¶¶ 10-19).

Where the subscriber is admitted to a hospital which is not a "member hospital", the Plan merely makes a cash payment directly to the subscriber in whole or partial reimbursement of his or her cost of hospitalization. Typically, this payment will be much less (amounting in some cases to only about 10% of the charges) than the full hospital charge. The benefit under this alternative is referred to as an "indemnity benefit" (A.83-84 ¶ 20).[2]

[1] References to "A." are to the single Appendix. References to "Ex." are to the separate volume of Exhibits to Appendix. References to "J.S." are to the Jurisdictional Statements of appellants.

The Blue Cross-Hospital Contract. There is no need for a Blue Cross Plan to have any contractual relationship with hospitals in a community in order to provide the indemnity benefit, which, as indicated above, is paid directly to the patient-subscriber. To provide the more comprehensive service benefit, however, a second class of contract is necessary, *i.e.*, between the Blue Cross Plan and the hospitals in a community (see A.80-81 ¶¶10-12). It is of major significance to this litigation that historically almost all major hospitals in Pennsylvania have been member hospitals contracting with Blue Cross (see A.83 ¶ 19). Indeed, until the recent defection of the hospital appellants in No. 75-1691 (the Delaware Valley Hospital Council-represented hospitals), litigation had arisen in exactly this direction, *i.e.*, appellee Blue Cross of Greater Philadelphia has been made a defendant for allegedly improperly refusing to admit a hospital to the widely desired status of member hospital. See, e.g., *Doctors*

[2] Appellants in No. 75-1698 incorrectly state (J.S. 19) that "(n)on-member hospitals, treating Blue Cross subscribers, receive a predetermined amount from Blue Cross." In point of fact, only "member hospitals" have a direct relationship with Blue Cross; in a "non-member hospital" admission, the Blue Cross payment is made to the subscriber, *not* to the hospital.

Hospital v. *Blue Cross of Greater Philadelphia*, No. 73-1057 (E.D. Pa. August 13, 1975), *aff'd per curiam*, No. 75-2166 (3rd Cir. April 28, 1976).

Transmutation of the Blue Cross-Hospital Contract into a Hospital Cost Containment Tool. The initial authorization for the creation of Blue Cross Plans in Pennsylvania was given by the enactment of the Nonprofit Hospital Plan Act, act of June 21, 1937 (P.L. 1948) and the companion act of June 21, 1937 (P.L. 1980), which amended the Nonprofit Corporation Law of 1933 to permit nonprofit hospitalization plans to be incorporated under the Nonprofit Corporation Law notwithstanding their regulation by the Insurance Department. These provisions are now codified at 40 Pa. C.S.A. §§6101-6127.

Generally speaking, the laws applicable to commercial insurers are not applicable to Blue Cross Plans. 40 Pa.C.S.A. §6103(a). A Plan may contract only with government-operated hospitals or with hospitals approved by the Department of Public Welfare. 40 Pa. C.S.A. §6121; 62 P.S. §1103;[3] 67 Pa.C.S.A. §6102; 71 P.S. §755-2. Blue Cross-hospital and Blue Cross-subscriber contracts are subject to Insurance Department approval. 40 Pa.C.S.A. § 6124(a). See generally *Insurance Department* v. *Saint Lukes Hospital of Bethlehem*, 342 A.2d 773 (Pa. Comm. Ct. 1975) (upholding in part refusal of Insurance Department to approve hospital contract submitted by Blue Cross of Lehigh Valley).

[3] Pennsylvania is undergoing a statutory codification program similar to the Revised Statutes. Codified provisions are cited as "Pa.C.S." (official version) and "Pa.C.S.A." (West's annotated version). Uncodified provisions are available only in West's unofficial *Purdon's Pennsylvania Statutes Annotated*, cited herein as "P.S." The distinction is operative and not merely formal, *e.g.*, 15 P.S. § 102 refers to a 1925 Act relating to acknowledgments, while 15 Pa.C.S.A. § 102 (which appears in a pocket part to another volume) refers to the definitions applicable generally to Title 15 of the new official codification.

Originally, the Blue Cross-hospital contracts called for Blue Cross to pay a flat per diem reimbursement to a hospital in order to purchase the hospital service required by a subscriber-patient. See *Travelers Ins. Co.*, *supra*, 361 F. Supp. at 778.

As successive Pennsylvania Insurance Commissioners began to appreciate the significance and magnitude of hospital cost inflation, a governmental policy was adopted to utilize the Blue Cross-hospital contract as a vehicle to control the rate of escalation of hospital costs (A.84-86 ¶¶ 21-28). This technique was feasible because over half the population of the Commonwealth of Pennsylvania is covered by Blue Cross benefits and, as noted earlier, almost all major hospitals in Pennsylvania contract with Blue Cross (A.79, A.83 ¶¶ 6, 19).

Accordingly, the Blue Cross-hospital contracts were revised in several stages until by 1971 the hospitals no longer received from Blue Cross a flat per diem reimbursement (which had always been less than the hospital's posted "charges" (or retail price)), but rather received only the actual cost (including depreciation

of capital assets) of providing the service to Blue Cross subscribers (A.84 ¶¶ 23-24). See also *Travelers Ins. Co., supra*, 361 F. Supp. at 778-79. These Blue Cross-hospital contracts are complex, but in general provide definitions of reimbursable costs and procedures for the resolution of disputed questions, including, where necessary, ultimate court review.

The Unanticipated Abandonment of Member Hospital Status by the Delaware Valley Hospital Council. The Delaware Valley Hospital Council (the "DVHC"), appellant in No. 75-1691, represents a group of approximately 30 hospitals which have since August 15, 1974[4] refused to extend voluntarily their Blue Cross-hospital contracts (contracts which have existed, in one form or another, since the inception of the Plan in southeastern Pennsylvania in the late 1930's). It is anticipated on all sides that any new contract, like all prior contracts, will take effect retroactively to August 15, 1974 (A.91 ¶ 47; Ex. no. 29).

The effect of the August 15, 1974 "termination" of the Blue Cross-hospital contracts was gradually to convert the DVHC hospitals from "member" to non-member hospitals over the period of a year. Under the

[4] Appellants in No. 75-1691 have variously asserted that the expiration date was June 30, 1974 (A.9 ¶ 9) or March 31, 1974 (Brief at 8). However, as the District Court expressly found (409 F. Supp. at 820; J.S. in No. 75-1691 at A6), appellants had agreed to an extension to August 15, 1974 (see Ex. 288a ¶ 5). Appellants are apparently straining to avoid the August 15, 1974 date because their contract with appellee Blue Cross therefore did not fully expire until August 15, 1975, *after* the enactment of Act No. 94.

so-called "run-out" provision of the contracts (see Ex. no. 23), the DVHC-represented hospitals were to lose their status as "member" hospitals with respect to any particular Blue Cross subscriber on the next annual renewal date of his or her Blue Cross-subscriber contract. Thus a progressively declining proportion of all Blue Cross subscribers were entitled to ""member" benefits in DVHC-represented hospitals, with the last group scheduled to lose such benefits on August 15, 1975 (one year after the commencement of the run-out period). The effect of this change is illustrated by the following hypothetical example:

Before the run-out, a Blue Cross subscriber who experienced a 9-day spell of hospitalization in a "member" hospital with a $150 per day rate[5] and a $120 per day "cost"[6] might have been presented on discharge with a $90 bill computed as follows:

Hospital "charges"	$150 per day
Cost of service as determined under the Blue Cross-hospital cost reimbursement formula	$120 per day

[5] Appellants suggest that the hospitals' list prices or "charges" may be as much as 40% more than their "reasonable costs" (Brief in No. 75-1691 at 7, Brief in No. 75-1698 at 3, 9), but a 25% profit or markup is utilized here for illustrative purposes.

[6] During the period involved the per diem "cost" rate in the DVHC-represented hospitals was in the range of $85 to $140 (Ex. no. 23, Ex. 288a-289a. See also Ex. no 31).

Paid by subscriber to hospital (required coinsurance under Blue Cross-subscriber contract) (9 x $10)[7]	$90
Paid by Blue Cross to hospital .....(9 x $120) — $90 =	$990
Total received by hospital	$1,080

After the run-out, the impact on the Blue Cross subscriber could be dramatically different, since the nonmember status of the hospital converts the Blue Cross program to a cash indemnity plan, and the hypothetical patient would be presented on discharge with a $1,350 bill:

Hospital "charges"	$150 per day
Paid by subscriber to hospital (9 × $150)	$1,350
Indemnity paid subsequently by Blue Cross to subscriber (1 × $50 + 8 × $25)[8]	$250
Net amount ultimately paid by subscriber	$1,100

Policy Options Available to the General Assembly. Faced with the unanticipated refusal of a sizable group of hospitals to agree voluntarily to charge no more than "cost" as defined in the last Blue Cross-hospital contracts approved by the Insurance Department (Ex.

[7] See, *e.g.*, Co-Pay Preferred Comprehensive Subscription Agreement, Article I, section 2 (Ex. 83a).

[8] See, *e.g.*, Co-Pay Preferred Comprehensive Subscription Agreement, Article I, Section 4A (Ex. 86a).

nos. 17, 18, 20 and 23), and with the lapse of the related regulatory requirements of such contracts, the General Assembly was faced with, *inter alia*, the following choices:

a. The creation of a permanent full-blown hospital regulatory scheme patterned after the Milk Control Board or the Pennsylvania Public Utility Commission (see Ex. no. 33A);

b. Authorize and require the Insurance Department on a permanent basis to fix the amounts which hospitals may charge Blue Cross or Blue Cross subscribers for Blue Cross subscriber admissions and to impose regulatory requirements similar to those contained in the lapsed contracts; or

c. Rely on the voluntary negotiation of Blue Cross-hospital contracts subject to Insurance Department approval, but strengthen the participation of the Insurance Department in the negotiating process as a permanent change and seek to "patch up" the up to 11½ month hiatus in regulation by prescribing as to this "locked-in" period cost-based rates on a formula which had been approved originally by the affected hospitals and which would be automatically superseded retroactively by any voluntary settlement which Blue Cross and the affected hospitals might, with the approval of the Insurance Department, elect to make.

Response of the General Assembly to the Problem. Eschewing the more radical solutions, the General As-

sembly opted for the minimum level response. On August 2, 1975, *prior* to the August 15, 1975 final run-out of the then existing Blue Cross-hospital contract with the DVHC-represented hospitals, it enacted Act No. 94. The Act has the following effects:

a. Where a Blue Cross-hospital contract was in existence on August 2, 1975, or where it is entered into then or thereafter, the contract (including primarily the cost reimbursement feature) may not thereafter be terminated without going through a "cooling-off" procedure involving notice to the Insurance Department, investigative hearing, recommendations by the Department, and further negotiations. (This is the only concern of the appellants in No. 75-1698, since they were in no way directly involved in the dispute between Blue Cross and the DVHC-represented hospitals, but had existing contracts which became subject to the mediation and cooling-off provisions of the statute.)

b. The remaining impact of the statute was confined to hospitals which had benefited substantially continuously from Blue Cross-hospital contracts during the *ten year* base period June 30, 1964 to June 30, 1974, but which were not covered (except for the application of the run-out period) by a Blue Cross-hospital contract on August 2, 1975 (all of the DVHC-represented hospital appellants in No. 75-1691 fall into this classification). As to these hospitals the last

approved Blue Cross-hospital contract on file with the Insurance Department was made applicable to August 2, 1975 and subsequent hospital admissions until a termination of the prior contract under the mediation and cooling-off provisions described in (a) above was effected, or unless and until the prior contract was retroactively superseded by a new agreement, voluntarily entered into between Blue Cross and the hospitals and approved by the Insurance Department.

c. In the case of hospitals covered by (b) above, the last approved Blue Cross-hospital contract was also made applicable to the operations of the hospitals during the "locked-in" period between August 15, 1974 and August 2, 1975, unless and until retroactively superseded by a new voluntary agreement as described in (b) above.

Act No. 94 could, of course, have been drafted simply to say that "cha.ges" for Blue Cross subscribers would be limited to those produced by the last approved reimbursement formula, without any language purporting to "reinstate" the expired contract. However, under the Blue Cross-subscriber agreements, unless the Blue Cross-DVHC contracts were technically reinstated the DVHC hospitals would have lost their status as "member hospitals." Had this occurred, many Blue Cross subscribers who were admitted to the DVHC hospitals would have received only the lower indemnity benefit (*e.g.*, per-

haps only 25% of the actual per diem charge), rather than the complete or almost complete service benefit; and subscribers would have been entitled to demand direct payment of the benefit check from Blue Cross, resulting in a dispersal among many individuals of funds which from a health delivery system point of view should be delivered in bulk by Blue Cross to the hospitals, and further requiring the hospitals to seek out the discharged Blue Cross subscribers to collect the amounts due the hospitals.

Returning to the earlier hypothetical example, if Act No. 94 had been drafted simply as a price control statute, the Blue Cross subscriber who expected to pay $90 on discharge would still have found it necessary to pay a net of $830 for his or her spell of hospitalization:

Hospital "charges" before controls	$150 per day
Hospital "charges" as determined under Blue Cross-hospital cost reimbursement formula adopted by Act No. 94	$120 per day
Paid by subscriber to hospital ($9 \times \$120$)	$1,080
Indemnity paid subsequently by Blue Cross to subscriber ($1 \times \$50 + 8 \times \$25$)	$250
Net amount ultimately paid by subscriber	$830

By characterizing the Blue Cross-hospital contract as "reinstated," Act No. 94 gave the DVHC-represented

hospitals "member hospital" status under the separate Blue Cross-*subscriber* contracts, thus, in the hypothetical example, restoring the Blue Cross-paid portion of the hospital bill to $990 from $250 and reducing the subscriber-paid portion from $830 to $90.[9]

Court proceedings. The appellants alleged in their amended complaint (A. 32 ¶ 9) that the action was brought by the named plaintiffs as, *inter alia*, representatives of a class as defined in Fed. R. Civ. P. 23. No order certifying class action status was ever entered below, and the opinion of the District Court does not contain the class findings required by Rule 23(c)(3).

In Count II of their amended complaint in the District Court (A. 36-37), appellants originally challenged Act No. 94 on the grounds that the Act is unconstitutional under the Equal Protection Clause as applied to Blue Cross-hospital contracts entered into after August 2, 1975. The equal protection rights asserted were those of commercial insurers, not those of any of the appellants. The District Court noted that this issue had been resolved by the Third Circuit in *Travelers Insurance Co.* v. *Blue Cross of Western Pa.*, 481 F.2d 80 (3rd Cir. 1973), *cert. denied*, 414 U.S. 1093 (1974), and both the majority and the dissenting judge below held that Act No. 94 in its prospective application is fully constitutional. In this Court,

[9] Throughout the balance of this Brief, all financial examples will be based on the hypothetical examples set forth herein.

appellants have abandoned their equal protection attack on the statute as well as their attack in respect of application of the statute to Blue Cross-hospital contracts entered into after August 2, 1975. Therefore, in this Court appellants are aligned as follows:

No. 75-1691 (*Guest et al.* v. *Fitzpatrick et al.*). Appellants in this appeal are the DVHC, the DVHC hospitals and related officials, who challenge Act No. 94 insofar as it reinstated the 1971-1974/75 Blue Cross-DVHC contract.

No. 75-1698 (*Williamsport Hospital et al.* v. *Fitzpatrick et al.*). Appellants in this appeal are Williamsport Hospital and The Hospital Association of Pennsylvania, who challenge Act No. 94 insofar as it imposes cooling-off and mediation procedures with respect to Blue Cross-hospital contracts existing on August 2, 1975. (Presentation of this issue by appellants in No. 75-1691 would obviously pose an embarrassing dilemma for them, since those appellants argue that they had no contract with Blue Cross on August 2, 1975, notwithstanding the fact that they had previously agreed that their existing contract would continue until August 15, 1975 as to certain Blue Cross subscribers.) The amended complaint (A. 32 ¶ 8) contains a vague statement that could be read as alleging that Act No. 94 operated to reinstate the Blue Cross-hospital contracts of unnamed hospitals (other than the DVHC group). No such hospital was ever identified on the record; appellants have not presented in their

Jurisdictional Statement any question relating to reinstatement of contracts; and appellees are not aware of the existence of any such reinstated contracts.

SUMMARY OF ARGUMENT

The unanticipated refusal of the principal group of hospitals in southeastern Pennsylvania to continue to provide hospitalization services under a 38-year-old program originally developed by the hospitals, and upon which over half of the affected population had come to rely, created an emergency condition with which the Pennsylvania General Assembly could constitutionally deal under the Commonwealth's police powers.

Insofar as Act No. 94 subjects appellants in No. 75-1698 to the strictures of a 10 month cooling-off and mediation period as a precondition to the cessation of services pursuant to the terms of contracts in existence on the date of enactment of the Act, the legislative response is merely an application of well-established principles developed in the context of the police regulation of the cessation of services by individuals. For example, at least since the decision of this Court in *Wilson* v. *New*, 243 U.S. 332 (1917), it has been clear that the police power may be used to require individuals providing essential services to the public to continue to provide such services during a statutorily-defined cooling off and mediation period, notwithstanding private contract provisions contemplating the cessation of such services as a bargaining tool or otherwise. Given the 38-year life of the existing Blue Cross-hospital program, the pattern of prior retroactive contract settlements and the public's justifiable reliance on a continuation of such pattern, and the institutional nature of the affected providers of the health services, there was clearly a rational basis for extending the mediation and cooling off principle to Pennsylvania hospitals who contract with Blue Cross.

Appellants repeated assertion that the statutory procedure does not contemplate (short of voluntary retroactive settlement of a disputed contract negotiation) recoupment from patients admitted and charged regulated rates during the cooling-off period is true but constitutionally irrelevant. The relevant and controlling fact is that after the cooling-off period expires (without voluntary retroactive settlement) the hospitals are wholly free of regulation and may effect all needed recoupment by temporarily or permanently adjusting upward their charges for post-cooling off admissions. This procedure has long been regarded as constitutional in other applications of State price regulation, since it merely shifts the time period during which the disputed fraction (here approximately 3% of the base charge) of earnings is received, and does not purport to deny it permanently.

Appellants compare apples with oranges since they contend that free care and other disputed items must be allowed as an expense, but overlook the fact that gifts, endowment income and other items are not recognized as income under the statutory formula. In any event the level of the temporary rates involved here is

clearly nonconfiscatory as a matter of law, since the rate formula (which is essentially the Medicare formula) is general in nature, expressly provides for the reimbursement of all costs applicable to the services provided to Blue Cross subscribers, and provides for judicial review of specific disputes. The Constitution does not require that Pennsylvania fund medical services for indigents through a regressive surcharge on Blue Cross premiums (which are collected on a per capita basis) rather than through its general income tax or other taxes, or that Pennsylvania choose commission-type hospital regulation over other alternatives.

The considerations outlined above are also directly applicable insofar as Act No. 94 subjects appellants in No. 75-1691 to the observance of temporary rates for the post-enactment period.

Insofar as the August 15, 1974 through August 2, 1975 locked-in period is concerned, the appellants in No. 75-1691 cannot rely upon the Contract Clause because their contracts with their patients never became "vested" in the constitutional sense, as they were highly tentative only, to be abandoned in favor of service contracts with Blue Cross upon the expected completion of the current contract negotiations.

Furthermore, on this record Pennsylvania was entitled to take the action which it did to eliminate the unanticipated and patently dangerous hiatus in the established system for delivering hospital services to a

substantial part of the population of the affected area and to eliminate invidious discrimination among Blue Cross subscribers who required hospitalization during the hiatus period.

ARGUMENT

I: TO BE VALID UNDER THE APPLICABLE CONSTITUTIONAL STANDARDS, IT IS REQUIRED ONLY THAT THERE BE A RATIONAL BASIS FOR THE STATUTORY RESPONSE OF THE PENNSYLVANIA LEGISLATURE TO THE HIATUS IN HOSPITALIZATION REGULATION CAUSED BY THE UNEXPECTED REFUSAL OF CERTAIN HOSPITALS TO SUBMIT NEW BLUE CROSS-HOSPITAL CONTRACTS TO THE PENNSYLVANIA INSURANCE DEPARTMENT FOR REGULATORY REVIEW AND APPROVAL.

Act No. 94 is a measure for the compulsory regulation of hospital rates and practices, enacted because of the emergency conditions existing in Pennsylvania due to the unanticipated break-down in the technically voluntary Blue Cross reimbursement and review system. Thus, the General Assembly in enacting Act No. 94 made a specific declaration of necessity:

> "It is hereby found that many subscribers to nonprofit hospital plans make payments over long periods of time prior to becoming entitled to benefits under such a plan and that it is important in the public interest that the reasonable expectations of such subscribers as to coverage should be fulfilled if possible. [10] It is hereby declared to be

[10] In an effort to avoid the thrust of this legislative finding, appellants in No. 75-1691 attack the Act as "outrageous" (Brief at 25) and all appellants urge that Blue Cross coverage is merely term insurance which creates no expectation of continued service in the local hos-

(footnote continued on following page)

> essential for the maintenance of the health of the residents of this Commonwealth that subscribers to nonprofit hospital plans be assured receipt of the hospitalization and related health benefits prepaid by them through payment of the rates approved under this chapter and charged by a hospital plan corporation and that to accomplish this essential purpose termination of contracts between hospital plan corporations and hospitals entered into pursuant to section 6121 (relating to eligible hospitals) and this section be subject to prior approval by the [Pennsylvania insurance] department as provided in this subsection." 40 Pa. C.S.A. § 6124(c)(1).

In assessing the validity of Act No. 94, a distinction must be drawn between the standards of review in respect of State economic regulation and State infringement of civil rights and liberties. Legislation touching on individual freedoms, and especially First Amendment freedoms, is subject to an exacting judicial review. Regulatory legislation as to economic matters, on the other hand, "is not to be pronounced unconstitutional unless in the light of the facts made known or generally assumed it is of such a character

pital. The only thing "outrageous" in this case is the smug assertion by the hospitals to the effect that after a Blue Cross subscriber has paid premiums for years, and perchance has acquired a serious or even terminal condition, he or she should go out and purchase commercial insurance "which has been available at all times" (Brief in No. 75-1691 at 26 n. 11). Obviously, there is no record citation in appellants' brief for this amazing and callous assertion.

as to preclude the assumption that it rests upon some rational basis within the knowledge and experience of the legislators." *United States* v. *Carolene Products Co.*, 304 U.S. 144, 152 (1938).

The theoretical basis for this bifurcated standard of review has been perhaps best stated by Mr. Justice Brandeis: "To stay experimentation in things social and economic is a grave responsibility. Denial of the right to experiment may be fraught with serious consequences to the Nation. It is one of the happy incidents of the Federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country." *New State Ice Co.* v. *Liebmann*, 285 U.S. 262, 311 (1932) (dissent). Viewed historically, this broader discretion permissible in respect of economic matters represents a reversal of the early standards for constitutional adjudication; as Professor Freund has put it,

> "there has been a Copernican revolution since the late nineteenth and early twentieth century: whereas formerly the Court (always over the dissents of some of its most respected members) was quick to strike down novel measures of economic and social reform in the name of due process of law and was slow to assimilate the First Amendment freedoms into the Fourteenth, today no real barrier is raised against legislative experiments in the economy but very severe obstacles face legislative restrictions on the launching of ideas." Paul A. Freund, *The Supreme Court of the United States* 24 (1961).

Thus, in assessing matters of economic regulation, this Court today does not sit as a superlegislature, requiring agreement with its own notions of policy. *Ferguson* v. *Skrupa*, 372 U.S. 726, 731-32 (1963). Rather, deference is granted to State legislatures and the Congress to reconcile conflicting interests within a broad zone of reasonableness.

Act No. 94 is, of course, a somewhat specialized type of economic regulation. That is, Act No. 94 is in operation and effect ratemaking legislation.[11] To recognize this fact, however, is not to turn a hospital into a public utility. At least as early as 1934 this Court recognized that the power of a legislature to impose rate regulation does not depend on utility status. See *Nebbia* v. *New York*, 291 U.S. 502 (1934). Indeed, the Natural Gas Act subjects producers of natural gas to a highly articulated scheme of rate regulation, and this Court has read that Act quite expansively while at the same time recognizing that "(p)roducers of natural gas cannot usefully be classified as public utilities." *Permian Basin Area Rate Cases*, 309 U.S. 747, 756 (1968).

[11] It is of course clear that in this Court the validity of Act No. 94 is to be tested by its substantive operation and effect as ratemaking legislation, so that the contract law "aura" in the statutory reinstatement language is not controlling. See *Lavine* v. *Milne*, 424 U.S. 577, 584 (1976).

For the reasons discussed below, it is clear that Act No. 94 (and particularly the legislative decision to characterize its action as the reinstatement of certain lapsed contractual relationships) is well within the band of constitutional discretion in matters of economic regulation permitted the General Assembly of the Commonwealth of Pennsylvania.

II: AS APPLIED TO EXISTING AND RECENTLY TERMINATED CONTRACTS FOR THE FURNISHING OF SERVICES, THE STATUTORY REMEDY FASHIONED BY PENNSYLVANIA REPRESENTS A RATIONAL AND THEREFORE CONSTITUTIONAL APPLICATION OF MEDIATION AND COOLING-OFF PROCEDURES.

A. The magnitude of the crisis facing the General Assembly was great. On a National level, health expenditures over the period 1950 to 1975 have almost doubled as a percentage of Gross National Product (4.6% to 8.3%) and of personal income (5.7% to 9.9%), with further increases predicted for the future (the Department of Health, Education and Welfare estimates that by 1990, 10% to 12% of Gross National Product will be spent for health care). Hospital expenditures are even higher than overall health expenditures, so that the cost of an average hospital stay is up from $311 in 1965 to $1017 in 1975; over the same period, the average length of hospital stays declined. Executive Office of the President, Council on Wage and Price Stability, Staff Report on "The Problem of Rising

Health Care Costs" at 4, 9, 23, 27 (April 1976) (GPO Stock No. 052-003-00164-1).

The situation in the area of appellant hospitals is even more egregious. While inpatient days have been declining, per diem hospital costs in the Philadelphia area rose from only $29.27 in 1964 to $117.83 in 1974, or 400% in 10 years, with $201.25 per diem projected for 1977 (Ex. nos. 31, 32).

To protect themselves from exposure to this economic risk, and to assure themselves the ability to obtain adequate health care, over half the population of the Commonwealth of Pennsylvania is covered by Blue Cross Plans (A.79 ¶ 6). Appellee Blue Cross of Greater Philadelphia alone has approximately 2,400,000 subscribers (A.78-79 ¶ 5). Thus, literally millions of Pennsylvania residents were subjected to a severe crisis situation by the unanticipated hiatus in their hospitalization coverage which, as noted above, could turn a $90 hospital bill into a $1350 one.

B. The statute. Act No. 94 establishes three time periods in respect of hospitalization contracts between hospital plan corporations and hospitals: a notification period, a hearing period and a negotiation period.

No hospitalization contract may be terminated unless the party seeking the termination gives 90 days advance written notice to the other party to the contract and to the Pennsylvania Insurance Department. If the notice is given 90 days before the scheduled

termination of the hospitalization contract, the contract will terminate in accordance with its terms. If, on the other hand, the dissatisfied party chooses to wait until the scheduled termination date before giving its notice, then the hospitalization contract will in effect be continued by virtue of the statute for the 90 day notification period. 40 Pa.C.S.A. § 6142(c)(2). Therefore as to appellants in No. 75-1698 (who do not allege that any of their contracts would have otherwise terminated prior to October 31, 1975–90 days after the August 2, 1975 effective date of Act No. 94), the mediation and cooling-off period is only the 10 months required for the procedures discussed immediately below.

If a termination involves hospitalization contracts with hospitals having more than 5% of the beds in the area served by a hospital plan corporation, the Insurance Department is required to hold public hearings. Pending completion of the Insurance Department's investigation, termination of the hospitalization contracts is suspended for a period not to exceed six months from the end of the notification period described above, and the contract is continued in accordance with its terms. Based on its investigation, the Insurance Department is required to make specific findings as to the facts of the dispute, and to approve termination of the hospitalization contracts or else recommend terms for the continuation of the contracts. Any recommendation of terms by the Insurance Department shall be "in the public interest, based upon the facts, the right of a hospital to be paid its costs for hospitalization services to subscribers and the need of subscribers for efficient, reliable hospitalization at a reasonable cost." 40 Pa. C.S.A. § 6142(c)(3).

Even if terms are recommended by the Insurance Department, the parties are under no obligation to accept such terms. Rather, the parties are required only to renew their negotiations in order to determine whether a new agreement can be reached substantially on the basis of the terms recommended. Pending such negotiations, termination of the hospitalization contracts is suspended for a period not to exceed 90 days from the expiration of the hearing period described above. If negotiations are unsuccessful, the Insurance Department is required to approve termination of the contracts, effective 30 days thereafter. 40 Pa.C.S.A. § 6142(c)(4).[12]

Thus, the legislature has established a carefully detailed and balanced procedure for the orderly termination of contracts greatly affecting the public interest. Notification, public hearings and possible further negotiations are provided for. The terms upon which the

[12] Appellants in No. 75-1691 would have this Court believe that they are ignorant of the purpose of the final 30 day delay (Brief at 18). The purpose, of course, is to afford time to notify all Blue Cross subscribers of the identity of the non-contracting hospitals, so that subscribers thereafter requiring hospitalization may request their physicians to admit them to member hospitals where service benefits will be available, *e.g.* where $90 rather than $1350 will be charged to the subscriber on discharge.

parties ultimately agree are automatically made retroactive to the date of expiration of the contract previously in effect. 40 Pa.C.S.A. § 6142(c)(5). This provision prevents those who require hospitalization during an inter-contract interval from suffering the invidious discrimination of paying $1100 for services for which others pay only $90 both before and after (and where a run-out is applicable, during) the inter-contract interval. Contracts having a minimal impact on the public interest (*i.e.*, hospitalization contracts with hospitals having 5% or less of the beds in the area served by the hospital plan corporation) are subject only to the requirement of 90 days' prior written notification of termination. In no event may a hospitalization contract be extended beyond 10 months (13 months as to appellants in No. 75-1691) from its intended final termination date. And in no event are terms of a new contract forced on the parties.

C. A temporary restoration or continuation of contractual arrangements is constitutionally permissible. As described above, Act No. 94 provides for the restoration or continuation of business relations between contracting parties for a limited period pending private negotiations as a means of alleviating a significant emergency in the public delivery of health care services. Thus, in providing a mechanism to put the Blue Cross system "back to work", Act No. 94 is in the tradition of the Taft-Hartley and Railway Labor Acts.

The constitutional validity of such a statute can be seen from a comparison of the workings and fates of the Taft-Hartley Act of 1947 and the Kansas Industrial Court Act of 1920.

The Federal statute provides for injunctive relief upon application by the Executive after public report by a board of inquiry in cases where a threatened or actual strike or lock-out affects an entire industry or a substantial part thereof engaged in interstate commerce, and if permitted to occur or continue will imperil the national health or safety. The Kansas statute provided for compulsory arbitration of labor disputes, forbade employers from going out of business unless they could show that financial collapse would follow if they continued on the terms fixed, and made strikes and lock-outs unlawful under pain of criminal sanctions.

The constitutionality of the Federal act has been sustained; the Kansas statute has been invalidated. *Steelworkers* v. *United States*, 361 U.S. 39 (1959); *Wolff Packing Co.* v. *Industrial Court*, 262 U.S. 522 (1923).

In assessing the validity of statutory restraints on the freedom of private parties to contract as they will, two factors are crucial. One is the severity of the restriction; it "must not be arbitrary or unreasonable." The other is the need for the curtailment: "exceptional circumstances" may justify otherwise overreaching arrangements. *Wolff, supra*, 262 U.S. at 534.

In terms of the nature of the restraint, it is clear that Act No. 94 presents a *Steelworkers* and not a *Wolff* situation. The Kansas statute sought to force a solution on the parties through compulsory arbitration; Taft-Hartley, on the other hand, provides that contractual arrangements "be resumed or continued for a time while efforts [are] made to settle the dispute." *Steelworkers, supra*, 361 U.S. at 41. Act No. 94, in providing a "cooling off" period during which private negotiations may continue, adopts the less restrictive Taft-Hartley philosophy of limited public encouragement to voluntarism.

In this connection, it should be noted that a relatively recent amendment to the Taft-Hartley Act provides that if a labor dispute affecting a health care institution (defined to include nonprofit hospitals such as appellants) would substantially interrupt the delivery of health care in the locality concerned, a board of inquiry may be established and "[there]after . . . and for 15 days after any such board has issued its report, no change in the status quo in effect prior to the expiration of the contract in the case of negotiations for a contract renewal, or in effect prior to the time of the impasse in the case of an initial bargaining negotiation, except by agreement, shall be made by the parties to the controversy." 29 U.S.C. § 183(c), as added by Public Law 93-360, 88 Stat. 396.

Nor is it controlling that the Act No. 94 cooling off period is somewhat longer than the periods provided in

the Taft-Hartley Act. The maximum cooling off period under the general provisions, 29 U.S.C. §§ 178-180, is 80 days. In view of the presumably greater resources of hospitals as compared with individual wage earners, and the virtually permanent relationship between Blue Cross and its member hospitals, the 10 month (13 month as to appellants in No. 75-1691) maximum cooling off period selected by the Pennsylvania General Assembly was obviously well within the ambit of legislative discretion.[13]

Apart from the limited severity of the restraint imposed by Act No. 94, the need for public protection is great. As Mr. Chief Justice Hughes stated in *Wolff*, "(t)he extent to which regulation may reasonably go varies with different kinds of business"; "(i)t depends on the nature of the business, on the feature which touches the public, and the abuses reasonably to be feared." 262 U.S. at 539. Thus, the "small extent of the injury" to the public that might result from a discontinuation of Wolff's packing plant did not

[13] Appellants attack the reliance of the District Court on the cooling-off line of cases, arguing that striking railroad workers could seek other employment but hospitals here are "compelled" to provide service to Blue Cross patients. It is open to question whether Act No. 94 provides any more than that *if* the hospital chooses to admit a Blue Cross subscriber *then* payment shall be subject to the terms of the statute (some member hospitals routinely turn away Blue Cross subscribers, *e.g.*, when they seek admission for premature termination of pregnancy procedures), thus giving the hospital the same theoretical freedom as the striking railroad worker. In practice the railroad worker and the hospital are both effectively tied to their respective callings, and the analogy drawn by the District Court is sound.

justify the "drastic regulation" sought to be imposed by Kansas. *Id.* at 543, 544. The public injury resulting from a discontinuation of subscribers' coverage, on the other hand, is direct, immediate, widespread and intense.[14]

Nor does it matter that steelworkers and railway employees today contract against the background of statutory contract continuation periods. Prior to the Railway Labor Act of 1926, in sustaining the constitutionality of the Adamson Law of 1916, this Court held that the legislative power "extend(s) to doing that which was essential to prevent operation [of the railroads] from being completely stopped by filling the interregnum created by an absence of a conventional standard of wages because of a dispute on that subject between the employers and employees by a legislative standard binding on employers and employees for such a time as might be deemed by the legislature reasonably adequate to enable normal conditions to come about as the result of agreements as to wages between

[14] Like *Wolff*, the *Fornaris* case cited by appellants is clearly distinguishable from Act No. 94 in terms of the severity of the restriction and the need for the curtailment. The Puerto Rico statute in *Fornaris* provided that dealership contracts with Puerto Rico dealers could *never* be terminated in accordance with their terms in the absence of a substantial failure of performance by the dealer. Act No. 94, on the other hand, imposes only a 10 month (13 month) restraint and provides an unlimited right of recoupment. Nor does the economic protection of hardware dealers compare to the protection of the public health. *Fornaris* v. *Ridge Tool Co.*, 423 F.2d 563 (1st Cir. 1970), *rev'd on other grounds*, 400 U.S. 41 (1970).

the parties." *Wilson* v. *New*, 243 U.S. 332, 351 (1917). The preexisting relationships there had been originally established prior to the enunciation of the doctrine of *Wilson* v. *New* (just as the Blue Cross-hospital relationship here had been established prior to the enactment of Act No. 94), thereby clearly demonstrating that the adoption of the ruling principle need not antedate the relationship affected. In any event, *Wilson* v. *New* was established law prior to the development of the Blue Cross concept in Pennsylvania in the 1930's.

D. Requiring Insurance Department approval of terminations is constitutionally permissible. If statutory extension of a contract for a cooling off period of up to 10 months (13 months) is constitutionally permissible, it is similarly allowable to condition termination of the contract during that period on the approval of the Pennsylvania Insurance Department.

The Natural Gas Act is typical of regulatory statutes in providing that companies may abandon jurisdictional facilities only with the prior permission of the administrative agency. 15 U.S.C. §717f(b). Under this provision, it is clear that the legislature may require performance of a contract pending administrative approval of termination notwithstanding the termination of the contract in accordance with its terms. *United Gas Pipe Line* v. *Federal Power Commission*, 385 U.S. 83 (1966).

United involved a contract for the sale of certain gas (the "Johnson Bayou gas") to run for 10 years and from year to year thereafter unless terminated by either party on 90 days' notice. Prior to the scheduled termination date of the primary term of the contract, the seller ("Continental") gave notice of its election to terminate. After fruitless negotiations for a new contract, the seller filed for and obtained a rate increase, effective as of the scheduled termination date of the primary term. The purchaser ("United"), after advance notice to the seller, ceased buying from the seller on the scheduled termination date. Upon petition by the seller, the regulatory commission held that the purchaser had abandoned facilities and services without obtaining its prior approval, in violation of the statute. Accordingly, the commission ordered the purchaser to resume its purchases from the seller at the new higher rate and in volumes consistent with the terms of the lapsed contract.

On appeal, this Court unanimously upheld the commission. After finding that the statute applied to the facts at hand, the Court reached the constitutional issue:

> "United claims that it does not need the Johnson Bayou gas to serve its customers and that the forced purchase of gas at prices set by Continental and approved by the Commission without regard to the prices at which United under contract or competition is bound to sell the gas deprives it of property without due process of law. In our view, these claims are premature. We do not hold that it would be inappropriate for the Commission to permit abandonment in this case if it is asked to do so and the necessary findings are made. We hold only that United has abandoned facilities and service without the consent of the Commission and that it must reactivate those facilities and restore the service until and unless the statutory consent is obtained." 385 U.S. at 91.

Similarly, in the case of Act No. 94, there is no constitutional infirmity in a statute conditioning termination of lapsed contracts on the obtaining of administrative approval.

Indeed, administrative approval of contract terminations is if anything more appropriate in the case of Act No. 94 than in *United*. *United* continued a contract altered to benefit one party; Act No. 94 simply leaves the parties where it finds them. In *United* it was past history and therefor clear which party was to be benefited; it is impossible to predict whether the hospital plan corporation or the hospitals will be advantaged by continuation of some future contract. In *United* all its future interstate gas purchases would presumably be subject to regulation and recoupment would be piecemeal at best; under Act No. 94, an unlimited recoupment right exists. And the statute in *United* permitted indefinite continuation of contracts, whereas Act No. 94 has a 10 month (13 month) limit.

It may be, of course, that a particular refusal to permit termination in some future dispute would constitute an abuse of administrative discretion, rendering Act No. 94 unconstitutional as there applied. But surely it would be, as this Court stated in *United*, "premature," at the outset of Pennsylvania's experiment to hold Act No. 94 unconstitutional on its face.

III: THE STATUTORY REMEDY FASHIONED BY PENNSYLVANIA CONTEMPLATES AN UNLIMITED RIGHT OF RECOUPMENT AND IS THEREFORE FREE OF CONSTITUTIONAL INFIRMITY

A. Pennsylvania has the power to regulate hospital charges. The constitutional standard for public regulation of the charges and other aspects of private enterprise derives from the common law concept of business affected with a public interest.

This concept was first generally enunciated in the United States through the decision of this Court in *Munn* v. *Illinois*, 94 U.S. 113 (1877). Upholding the authority of the Illinois legislature to fix the maximum rates charged by a specified class of grain warehouses, Mr. Chief Justice Waite was led

> "to inquire as to the principles upon which this power of regulation rests, in order that we may determine what is within and what is without its operative effect. Looking, then, to the common law, from whence came the right which the Constitution protects, we find that when private property

> is 'affected with a public interest, it ceases to be *juris privati* only.' This was said by Lord Chief Justice Hale more than two hundred years ago, in his treatise *De Portibus Maris*, 1 Harg. Law Tracts 78, and has been accepted without objection as an essential element in the law of property ever since. Property does become clothed with a public interest when used in a manner to make it of public consequence, and affect the community at large . . .
>
> "*It matters not in this case that these plaintiffs in error had built their warehouses and established their business before the regulations complained of were adopted.* What they did was from the beginning subject to the power of the body politic to require them to conform to such regulations as might be established by the proper authorities for the common good." 94 U.S. at 125-26, 133 (emphasis supplied).

Following *Munn*, the courts struggled with the public interest standard, upholding certain State laws and, especially during the heyday of substantive due process, invalidating others. The uncertainties in the *Munn* test were finally put to rest with this Court's announcement of the modern conception of the scope of the police power in *Nebbia* v. *New York*, 291 U.S. 502 (1934). Since *Nebbia*, few State economic statutes have been held by this Court to be beyond the power of the legislature to enact.

Nebbia upheld the authority of the New York legislature to fix the rates charged by stores for certain

retail sales of milk. Rejecting the assertion that regulation is only permissible in respect of public utilities, monopolies or businesses holding public franchises, this Court in *Nebbia* explained the true basis of its holding in *Munn*:

> "It is true that the court [therein] cited a statement from Lord Hale's *De Portibus Maris*, to the effect that when private property is 'affected with a public interest, it ceases to be *juris privati* only'; but the court proceeded at once to define what it understood by the expression, saying: 'Property does become clothed with a public interest when used in a manner to make it of public consequence, and affect the community at large' (p. 126). Thus understood, 'affected with a public interest' is the equivalent of 'subject to the exercise of the police power'; and it is plain that nothing more was intended by the expression . . .
>
> "It is clear that there is no closed class or category of businesses affected with a public interest, and the function of courts in the application of the Fifth and Fourteenth Amendments is to determine in each case whether circumstances vindicate the challenged regulation as a reasonable exertion of governmental authority or condemn it as arbitrary or discriminatory. *Wolff Packing Co.* v. *Industrial Court*, 262 U.S. 522, 535. The phrase 'affected with a public interest' can, in the nature of things, mean no more than that an industry, for adequate reason, is subject to control for the public good.

> "Price control, like any other form of regulation is unconstitutional only if arbitrary, discriminatory, or demonstrably irrelevant to the policy the legislature is free to adopt." 291 U.S. at 532-33, 536, 539.

Thus, State regulation of hospital rates is valid if "a reasonable exertion of governmental authority." And if grain elevators *(Munn)*, milk sales *(Nebbia)*, and gas producers (*Phillips Petroleum Corp.* v. *Wisconsin*, 347 U.S. 672 (1954)), are subject to economic regulation, it cannot be gainsaid that hospitals are sufficiently "affected with a public interest" also to be amenable to such controls. Indeed, as indicated in Part 1 of Annex A, hospitalization has been regarded as a "public service" under Pennsylvania law since the beginning.

B. Pennsylvania may implement its regulatory scheme by incorporating by reference a filed rate formula. The effect of Act No. 94 is to impose a maximum 10 month (13 month) rate regulatory scheme on hospitals. Appellants would have this Court hold that the only option constitutionally open to the Commonwealth of Pennsylvania was the creation of a full-blown hospital regulatory commission. Rather than undergo the delay and expense of such an endeavor, the General Assembly chose to adopt by reference the regulatory formulae contained in contracts, some lapsed, filed with and approved by the Pennsylvania Insurance Department.

It is clear that the legislature could have directly enacted the ratemaking formulae. Indeed, this is precisely how the Illinois legislature fixed the formula in *Munn*, and this Court therein noted that "(i)n countries where the common law prevails [this] has been customary from time immemorial." 94 U.S. at 133. Alternatively, the legislature could have incorporated by reference a ratemaking formula fixed by administrative agency regulation. Such was the approach of the New York legislature in *Nebbia*. Finally, authority may be given an administrative agency to require that the company subject to rate regulation file a schedule of rates, with the agency having the power to approve or reject such rates. See, e.g., *Pennsylvania Water and Power Co.* v. *Federal Power Commission*, 343 U.S. 414, 416-17 (1952).

Nor is it unusual to find a ratemaking scheme based on administrative approval or disapproval of rates filed by the regulated company. Indeed, many States, in addition to Pennsylvania, have adopted precisely this approach for Blue Cross ratemaking purposes. See, *e.g.*, Part 2 of Annex A. See also Part 3 of Annex A (Federal regulation).

Thus, there is no invalidity in a formula's being contained in a private contract where an administrative agency of the State, exercising its quasi-legislative authority to set rates, has passed on and approved the formula in a prior filing with the agency.

C. The right of unlimited post-cooling off recoupment afforded by Act No. 94 eliminates the issue of confiscation. It is a commonplace that when costs are rising a regulated industry complains about "regulatory lag," *i.e.*, the delayed price relief caused by the wait for the outcome of the price-setting process.[15] But the process works both ways, of course, and when costs are falling the consumer may be injured by delays in fixing lower rates or prices.

In *Prendergast* v. *New York Tel. Co.*, 262 U.S. 43 (1923), relied upon by the dissenting judge below, this Court overturned an effort by New York to fix lower temporary rates prior to the completion of the normal regulatory process. The Court noted that a bond for refund would protect the customer, but that New York had afforded no comparable protection for the telephone company if the temporary rates proved to be lower than the final rates. 262 U.S. at 51. *Prendergast* triggered the development of the concept of "recoupment," *i.e.*, the right of the regulated entity to make up any shortfall caused by temporary rates,

[15] It has long been assumed that where regulatory lag delays a rate *increase* for a reasonable period of time, no confiscation issue of constitutional dimension is raised since the delay is merely incident to the process of regulation. See, e.g., *New Rochelle Water Co.* v. *Public Service Comm'n*, 31 N.Y.2d 397, 292 N.E.2d 767 (1972) (10 month delay constitutional); *Hope Natural Gas Co.* v. *Federal Power Comm'n*, 196 F.2d 803, *rehearing denied*, 197 F.2d 522 (4th Cir. 1952) (5 month delay constitutional). However, because appellants in No. 75-1691 assert that Act No. 94 *reduced* their rates, the following recoupment discussion is relevant. *New Rochelle Water Co., supra*, 292 N.E. 2d at 773.

not by retroactively repricing services previously furnished (as appellants here seem to think), but by prospectively raising the price of currently-furnished services to recoup any deficiency in revenue.

The recoupment principle was sustained in *Bronx Gas & Elec. Co.* v. *Maltbie*, 271 N.Y. 364, 3 N.E. 2d 512 (1936). Its constitutionality was argued before this Court in *Driscoll* v. *Edison Light & Power Co.*, 307 U.S. 104 (1939), but only Justices Frankfurter and Black reached the issue and sustained the principle, the majority of the Court preferring to decide the case on the substantive due process grounds then still in vogue with respect to economic matters. Finally in *Beaver Valley Water Co.* v. *Driscoll*, 28 F. Supp. 722 (W.D. Pa. 1939), a three-judge district court squarely upheld the constitutionality of the recoupment alternative.

With the eclipse of this Court's substantive due process involvement in economic regulation, see, *e.g.*, *Day-Brite Lighting, Inc.* v. *Missouri*, 342 U.S. 421, 424-25 (1952), the issue appears never to have returned to this Court, but its application is obvious. A regulatory agency may, without making a formal adjudication on the confiscation question, permit rates to be increased, if the rights of the consumer are protected by a refund obligation. Correspondingly, as here, the regulatory authority may, without becoming entangled in the thicket of the confiscation question, require rates to be decreased, if there is a clear right to recover any lost revenue.

Here the amount in dispute is approximately 3% of the base charge,[16] the regulated industry is well situated to administer any required price increases (indeed, appellants confess that the hospitals are able to maintain the unregulated portion of their charges at levels as much as 40% above the regulated levels. Brief in No. 75-1691 at 7, Brief in No. 75-1698 at 3, 9), and the statute provides an unrestricted opportunity to charge as much as the traffic will bear after the expiration of the 10 month (13 month) cooling-off period (assuming no retroactive contract has been voluntarily agreed to in the interim). Under the circumstances, appellants confiscation arguments are too remote and speculative to justify reversal of the District Court's judgment.

IV: THE COST-OF-SERVICE RATE FORMULA CONTAINED IN THE BLUE CROSS-DVHC CONTRACT DOES NOT RESULT IN HOSPITAL RATES FOR BLUE CROSS SUBSCRIBERS WHICH FALL BELOW THE CONSTITUTIONAL ZONE OF REASONABLENESS

A. Structure and purpose of the Blue Cross-DVHC contract. The July 1, 1971 contract between Blue Cross and DVHC incorporated by reference by Act

[16] The prior Blue Cross-DVHC contract provided no "plus factors." The latest position of the parties is that a settlement can be effected between Blue Cross and DVHC if a 3% "plus factor" is added to the reimbursement to cover the aggregate of the omitted items disputed herein.

No. 94 appears as Exhibit no. 17 (Ex. 147a-262a), and prior to the enactment of the Act was amended as of July 1, 1972 (Ex. no. 18, Ex. 263a-265a) and was amended and extended by the so-called "Summary of Principles" (Ex. no. 20, Ex. 269a-285a) and the settlement in *Crozer-Chester* v. *Blue Cross of Greater Philadelphia* (Ex. no. 23, Ex. 286a-289a).

The Blue Cross-DVHC contract is a formidable document, representing the culmination of more than three decades of joint effort among the Pennsylvania Insurance Department, the hospitals and Blue Cross to hone the techniques for purchase of hospitalization service to a fine edge. In addition to covering routine business matters, the contract is a regulatory tool of major significance, *e.g.:* unnecessary hospitalization is monitored and discouraged (§§ 2.3, 11) (Ex. 152a, 162a-164a); duplication of laboratory tests is discouraged (§ 7) (Ex. 157a-158a); fees for professional services are limited to "reasonable and customary" charges and a report of fees of anesthesiologists, pathologists and radiologists must be made to the trustees of the hospital (§§ 10.1.2, 10.2) (Ex. 160a, 162a); cost saving programs, systems analysis and use of modern management techniques are encouraged (§§ 12-14) (Ex. 164a-166a); the dispensing of drugs by generic name is required (§ 16) (Ex. 166a-167a); the "prudent buyer concept" of purchasing is required (§ 19) (Ex. 173a-174a); a detailed safety program is imposed (§ 20 and Exhibit C) (Ex. 174a, 260a-262a); the hospital is required to maintain accredited status

(§ 23) (Ex. 176a); capital projects in excess of $100,000 and expansion of certain "big ticket" services such as open-heart surgery and hemodialysis are made subject to prior approval of an independent health planning agency (§ 24) (Ex. 177a-181a, 271a-272a); and costs, facilities and services information is to be made open to the public (§ 28) (Ex. 183a). Disputes arising under the contract may be appealed to a court, where they are heard *de novo* (§ 21) (Ex. 174a-176a, 271a).

Of course, it is in the area of regulating the rates to be charged for services to Blue Cross subscribers that the contract most clearly manifests its regulatory character. The hospitals are required to submit detailed budgets under a prescribed uniform accounting format at least 45 days prior to the fiscal year; the budget undergoes a detailed professional review by the Blue Cross staff and, unless appealed, the Blue Cross decision on an interim rate is final (§ 18 and Budget Forms A through K) (Ex. 168a-170a, 222a-259a). The *Crozer-Chester* litigation was an example of the hospitals' exercise of their right to have court review of the Blue Cross-fixed interim reimbursement rates (see Ex. no. 23) (Ex. 287a-289a) (*see also* generally A.91-92 ¶ 48). As of the end of each fiscal quarter, the hospital submits actual cost reports to Blue Cross. Based on this experience the interim rate may be adjusted, both retroactively and prospectively. Following the end of a fiscal year, final settlement is made

based on actual cost as verified by independent certified public accountants and subscriber usage for the period (§ 2.4.5 of Exhibit A) (Ex. 218a-219a) with, of course, a right to appeal for *de novo* review in the courts (*see also* A.92 §§ 50, 52).

The basis of payment to the hospitals is set out in Exhibit A to the contract (Ex. 185a-220a).[17] Essentially the basis of payment is derived from certain "principles" promulgated under Medicare[18] on July 1, 1967, and therefore all "current and future" Medicare interpretations, instructions and manuals relating to determinations of cost are expressly made applicable, except where the specific text of Exhibit A to the Blue Cross-DVHC contract would make such material inappropriate (Ex. 185a).

Since a typical hospital will have four classes of patients, *i.e.*, Medicare, Medicaid, Blue Cross and so-called "self-pay," a fundamental requirement of the formula is that "reasonable costs associated with Subscriber Covered Services will not be borne by individuals not so covered and the costs with respect to individuals not so covered will not be borne by Blue Cross." Principle 2.1.1(a) (Ex. 207a). *Cf.* 20 C.F.R.

[17] The "prospective rate base" method (§ 18.5 of the contract and Part II of Exhibit A thereto) (Ex. 172a-173a, 220a-221a) is an alternative incentive method of payment which permits Blue Cross and a hospital to fix a firm rate prospectively, so that any savings thereafter resulting inure to the benefit of the hospital. None of the DVHC hospitals had elected this option at the time Act No. 94 was enacted.

[18] See generally 42 U.S.C. § 1395x(v) and 20 C.F.R. §§ 405.401-405.488.

§ 405.402(a). The contract expressly declares that "payments to the [hospital] . . . should be fair and equitable to both the [hospital] . . . and Blue Cross." Principle 2.1.2(a) (Ex. 208a).

This general approach is then refined by a number of specific provisions. Depreciation is allowable not only upon purchased assets, but also upon assets furnished by private donations or by Hill-Burton or other Federal or public funds. Principle 1.1 (Ex. 186a-189a). *Cf.* 20 C.F.R. §§ 405.415-405.418. Interest expense on both current and capital indebtedness is allowable (the DVHC form of contract is drafted specifically for nonprofit institutions and therefore has no occasion to provide for return on equity capital[19]) Principle 1.2 (Ex. 189a-191a). *Cf.* 20 C.F.R. § 405.419.

Bad debts (except with respect to certain deductibles and co-insurance amounts), charity and courtesy allowances are treated as deductions from revenue and are not included in allowable costs. Principle 1.3 (Ex. 191a-194a). *Cf.* 20 C.F.R. § 405.420. However, offsetting this is the principle that unrestricted grants, gifts, and income from endowments should not be deducted from operating expenses in computing reimbursable costs. Principle 1.6 (Ex. 200a-201a). *Cf.* 20 C.F.R. § 405.423.

Identifiable costs incurred directly or indirectly for research purposes which exceed normal costs of usual

[19] Therefore appellants' reliance on *Denver Union Stock Yard Co.* v. *United States*, 304 U.S. 470 (1938), and similar "reasonable rate of return" cases is wholly inapposite.

patient care and are not otherwise reimbursed are excluded from allowable cost. Principle 1.5 (Ex. 199a-200a). *Cf.* 20 C.F.R. § 405.422. But the net cost of approved educational activities is an allowable cost. Principle 1.4 (Ex. 194a-199a). *Cf.* 20 C.F.R. § 405.421.

B. The real purpose of the appellants in attacking the rate formula is to eviscerate Pennsylvania's hospital regulatory program. The appellants complain of the relatively low Blue Cross indemnity benefit and urge that Pennsylvania should require full "charges" reimbursement (Brief in No. 75-1698 at 4). If that were so there would, of course, be no reason for any hospital to contract with Blue Cross and the whole indirect method of hospital regulation in Pennsylvania would collapse. Each hospital could charge what it liked, buy as many "big ticket" units as it desired, use only the most expensive brand name drugs, and so forth. The President of Blue Cross testified that in his view the real basis for the hospitals' complaint was that the cost control features of the 1971 Blue Cross-DVHC contract were having their intended "bite", *e.g.*, on disallowance of depreciation for unneeded facilities, refusal to reimburse medically inappropriate hospitalization and failure to use generic drugs and to conform to the prudent buyer concept (A.133 ¶ 89).[20]

[20] It should be noted that many of the contract requirements in effect mandate hospital-wide practices (*e.g.*, safety, accreditation, purchasing, generic drug use) and thus indirectly but quite effectively benefit the "self-pay" patient population.

Appellants in No. 75-1698 are candid enough to confirm that their aim is to eviscerate the cost control efforts of Medicare, Medicaid and Blue Cross, which refuse to pay for, *inter alia*, "misutilized patient days" (J.S. 16).

C. Appellants lack standing to raise an issue of confiscation. The law of confiscation as it has developed in this Court is a manifestation of the concern of the Court with the indirect taking of the private property interests of the owners of a business through overly stringent price regulation. Under the law of Pennsylvania, however, the appellants who are directors and officers of the appellant hospitals have, as such, no individual interest in the property of the hospitals. 15 Pa.C.S.A. § 7553. The appellant hospitals as corporations constitute, of course, only their individual members clothed with the immunity of limited liability. Under Pennsylvania law the members of a nonprofit hospital corporation have no interest in the assets of the hospital during its operation (15 Pa.C.S.A. § 7553). The assets of the hospitals are clearly committed to "charitable purposes" as that term is used in the applicable statute (15 Pa.C.S.A. § 7103), and at dissolution the assets are not distributable to the members but rather are subject to redeployment at the hands of the Commonwealth under a statutory codification of the *cy pres* principle. 15 Pa.C.S.A. §§ 7549(b), 7967(c). Therefore, to the extent that Act No. 94

represents a legislative decision that a part of the assets of these nonprofit charitable hospitals shall be utilized for the support of medical care for indigents (and other disputed matters), it represents an exercise of conventional State regulation of private charity which implicates no Federal claim under the Due Process Clause based on a taking theory.[21] Cf. *Simon* v. *Eastern Kentucky Welfare Rights Org.*, 48 L. Ed. 2d 450, 461 (1976) ("The necessity that the plaintiff who seeks to invoke judicial power stand to profit in some personal interest remains an Art III requirement").

D. Confiscation exists for constitutional purposes only where the end result of the rate formula is below the zone of reasonableness. The decision in *Smyth* v. *Ames*, 169 U.S. 466 (1898), laid down the rule of a fair return on a fair value as the test of a ratemaking

[21] Under a modern development, some of the hospitals may have no members. 15 Pa.C.S.A. § 7316(a)(7). At one time the charitable corporation, viewed as a juridical entity, had rights as against the State which created it. *Dartmouth College* v. *Woodward*, 4 Wheat. 518 (1819). But Pennsylvania, like the other States, has by appropriate constitutional and statutory provisions reestablished its unrestricted right to modify or abolish its corporate creations. Constitution, Art. X, §§ 1-3; 15 P.S. § 3, 15 P.S. § 4 note, 15 Pa.C.S.A. § 106. The record shows that with the possible exception of Pennsylvania Hospital (discussed separately in Part 1 of Annex A) which is in any event a corporation having members, all incorporated hospitals in Pennsylvania are fully subject to the legislative power of the Commonwealth (A.93-94 ¶ 56). *See generally* "Foreword" to *Purdon's Pennsylvania Statutes Annotated*, Titles 13-15, at 63-64.

formula. Following *Smyth* v. *Ames*, the courts determined questions of fair value of rate base and fair rate of return thereon. See, e.g., *Prendergast*, *supra*. Finally the rule of *Smyth v. Ames*, with its emphasis on close judicial supervision of ratemaking, was abandoned.

This Court has now indicated that the Constitution is concerned with the results of rates fixed rather than with the method used in arriving at them. Under the rule of *Hope Natural Gas Co. v. Federal Power Commission*, 320 U.S. 591 (1944), ratemaking methods are left to legislatures and administrative agencies exercising their quasi-legislative ratemaking function, with the role of the courts being confined only to determining whether the rates established are actually confiscatory in operation.

In *Hope Natural Gas*, this Court upheld a rate order issued by the Federal Power Commission as just and reasonable for purposes of the Natural Gas Act.[22] "It is not theory but the impact of the rate order which counts," this Court stated. "If the total effect of the rate order cannot be said to be unjust and reasonable, judicial inquiry . . . is at an end." 320 U.S. at 602. Applying its end result test to the order reducing Hope's rates, the Court held that "Rates which enable

[22] Although *Hope Natural Gas* turned on the construction of a Federal statute, the test therein announced coincides with the constitutional standard. *Federal Power Commission* v. *Natural Gas Pipeline Co.*, 315 U.S. 575, 586 (1942); *Permian Basin Area Rate Cases*, *supra*, 390 U.S. at 770, 780-81 (upholding a 22 month "moratorium" on rate increases).

the company to operate successfully, to maintain its financial integrity, to attract capital, and to compensate its investors for the risks assumed certainly cannot be condemned as invalid." *Id.* at 605.

E. The Medicare-based rate formula reimburses the hospitals for the full costs of serving Blue Cross subscribers, and no more is required by the Constitution. Appellants' confiscation claims are not a model of precision. At no point in this litigation have they identified specifically that language in Exhibit A to the Blue Cross-DVHC contract which they consider constiutionally offensive. However, they variously complain of failure to reimburse for care to indigent patients, bad debts (including particularly patients who enter a hospital as Blue Cross subscribers and exhaust their coverage before their treatment is complete), research and "operating growth needs."

At least since *Lindheimer* v. *Illinois Tel. Co.*, 292 U.S. 151 (1934), it has been clear that regulated rates need not include "provisions for capital additions, over and above the amounts required for capital consumption." 292 U.S. at 174. Similarly, denial of an allowance for research represents an application of this principal to accumulations for the acquisition of intangible assets in the form of expanded knowledge, and the costs of which in any event should be matched to the excluded gift, grant and endowment income.

Bad debts arising from Blue Cross subscribers exhausting their coverage must necessarily be excluded,

or there would be a rule of constitutional dimension that a third-party payor could never limit the amount of coverage. Obviously, if Blue Cross must reimburse the hospital for services beyond the exhaustion date, that date is meaningless. In any event, on September 13, 1976 Pennsylvania amended its Medicaid regulations, 6 Pa. B. 3050, to provide that when "the period covered by a Blue Cross contract . . . ends, the patient is eligible for full [Medicaid] . . . benefits."

The principal issue is the allocation of cost of indigent care. The rate formula matches costs and revenues by excluding both the cost of service to indigents and gift, grant and endowment income, which has been a traditional source of funding for medical services to the poor. Appellants, however, seek to have this Court ordain that the only method of supporting hospitalization for indigents open to Pennsylvania is by surcharge on the Blue Cross rates. As appellants in No. 75-1698 readily concede, the locus of the burden of medical care for indigents is a policy question. Brief at 5, 11, 22. As such, at least since *Hope Natural Gas*, it has in this Court not been viewed as a justiciable question. Two Blue Cross subscribers, one earning $100,000 and the other $10,000 per year, may be asked to bear a total of $20 as their share of indigent medical care. Imbedding that cost in the Blue Cross rate structure will allocate the burden on a per capita basis. But Pennsylvania is surely free under the Due Process Clause to elect direct Medicaid payments to the hos-

pitals and to utilize its 2% State income tax as the allocation means, resulting in a spreading of the cost according to ability to pay (*i.e.*, $18.18 to $1.82, rather than $10 to both).

As noted above, appellants in No. 75-1698 point out no fewer than three times that inclusion of the disputed items in the Act No. 94 reimbursement formula is a matter of policy (Brief at 5, 11, 22). As they also concede, the Pennsylvania General Assembly has been responding to the hospitals' complaints that the existing Medicaid formula is unsatisfactory (Brief at 10).[23]

The policy nature of this precise point has been reached in *dictum* by the New York Court of Appeals:

> "Theoretically, it could be argued, and legally sustained, that the voluntary [*i.e.*, non-profit] hospitals are entitled to reimbursement limited to the allocated cost of providing services for [Blue Cross] subscribers. Instead, by [New York] statute and regulation the [Blue Cross] subscribers through the reimbursement scheme are required also to contribute to non-income producing services required of the voluntary hospitals from which the paying subscribers may and usually receive no benefit...
>
> "The nub of the vexing problem is that hospital costs have been spiraling out of reach of an economically tolerable rate-structure for [Blue Cross], that is, the rate-structure under which it charges premiums to subscribers. Some of these costs have nothing to do with the costs directly allocable to the services rendered to the subscriber.
>
> "*Neither [Blue Cross] nor the subscribers owe a duty morally or legally, except for the statute now applied, to support the hospitals, but only to pay an allocable share of that support, not less than the cost of the services received by the subscribers, who are paying patients.*" *Presbyterian Hospital* v. *Ingraham*, 39 N.Y.2d 867, 386 N.Y.S.2d 217 (1976) (emphasis supplied).[24]

[23] *See* act of July 15, 1976 (No. 202), amending act of June 13, 1967 (P.L. 31), § 443.1 (62 P.S. § 433.1), by eliminating a 60-day benefit period limitation.

In this connection, the Massachusetts courts have held that, although indigent care *may* be included in the Blue Cross reimbursement formula, there is no requirement that such formula *must* include disputed

[24] While unnecessary to a decision at this point, appellees pointed out below that the hospitals could not surmount the overall loss test of *Wilcox* v. *Consolidated Gas Co.*, 212 U.S. 19, 54 (1909). For confiscation purposes it is necessary to add back "depreciation" expense claimed on contributed property. *Lindheimer*, *supra*, 292 U.S. at 167 (depreciation expenses for ratemaking purposes need only provide an allowance "to maintain the integrity of the investment"). See also *United States* v. *Chicago B. & Q.R. Co.*, 412 U.S. 401 (1973) (denying depreciation deductions for Federal income tax purposes in respect of facilities paid for from public funds); *Detroit Edison Co.* v. *Comm'r*, 319 U.S. 78 (1943) (denying depreciation deductions for Federal income tax purposes in respect of facilities paid for by customers). "Depreciation reflects the cost of an existing capital asset, not the cost of a potential replacement," and the cost to appellant hospitals of contributed property is zero. *Chicago, B. & Q.R. Co. supra*, 412 U.S. at 415. The record shows that without such "depreciation deductions", the appellants very likely would show an overall profit (A135-36 ¶ 3).

items. Compare *Massachusetts Hosp. Serv., Inc.* v. *Commissioner of Admin.*, 218 N.E. 2d 383 (Mass. 1966), with *Murphy Nursing Home* v. *Rate Setting Commission*, 305 N.E. 2d 837, 842 (Mass. 1973).

Moreover, it should be noted that all but one of the appellant hospitals accepts Hill-Burton funds from the Federal government (A.131 ¶ 84), thereby obligating themselves to provide "a reasonable volume" of free care to indigents. 42 U.S.C. § 291c(i)(2). See *Corum* v. *Beth Israel Medical Center*, 359 F. Supp. 909, 917 (S.D.N.Y. 1973) ("a recipient of Hill Burton funds is required by the statute to provide such services in such portion or portions of its facility as will constitute a reasonable volume in light of the needs of the community and the amount of the grant").

The District Court in the instant case found that the omissions from the rate formula adopted by Pennsylvania were permissible. Similarly, the omissions from the Massachusetts formula were sustained by this Court. *Murphy Nursing Home, supra*, 305 N.E. 2d 837 (Mass. 1973) (no issue of confiscation arises where provider is not legally obligated to receive and care for nonincluded indigent patients), *appeal dismissed for want of a substantial federal question*, 417 U.S. 962 (1974). As the District Court noted, except for voluntarily incurred Hill-Burton obligations, there is no legal requirement that hospitals in Pennsylvania render indigent care. 409 F. Supp. at 826. Thus, appellants would impose on Blue Cross subscribers a

constitutional duty to contribute to a charity of appellants' choosing, *i.e.*, to underwrite the cost of charitable endeavors voluntarily engaged in by "charitable" hospitals.[25]

Other disputed omissions from the Pennsylvania formula are similar. For example, to read into the Constitution a requirement that hospitals be reimbursed for free care provided to highly compensated doctors and their families is, to say the least, novel.

To be sure, reasonable men may differ as to whether or not indigent care and other disputed items should be factored into the rate formula as a matter of public policy.[26] But a legislative decision against such inclusion, certainly as applied to non-profit hospitals (whose charitable endowment is not a credit in the rate formula, who have tax-exempt dollars in their institutional

[25] Appellants in No. 75-1691 take the District Court to task (J.S. 19-20) for allegedly failing to perceive the charitable nature of the appellants, all of which are nonprofit charitable institutions. But it is precisely because appellants are committed to charity that they cannot, certainly as a constitutional matter, force the Blue Cross subscriber to pay for the costs of the work which the hospitals hold out as a charity. Appellants' view of "charity" smacks of a private tax levied upon those fortunate enough to enjoy Blue Cross benefits.

[26] Appellants in No. 75-1691 point out that the 1970 "Accreditation Manual for Hospitals" published by the Joint Commission on Accreditation of Hospitals, views indigent care as a laudable goal (Brief at 29-30). As appellees have pointed out, however, the "Principles of Payment for Hospital Care" published by the American Hospital Association at the inception of the Medicare program, expressly stated that reimbursement for such expenses was unquestionably improper (A.120 ¶¶ 60, 61).

pockets, who have recently benefited from an increase in welfare payments, and who stand to benefit further from future increases in welfare payments), is rational and therefore permissible. "So long as its judgments are rational, and not invidious, the legislature's efforts to tackle the problems of the poor and the needy are not subject to a constitutional straightjacket." *Mathews* v. *de Castro*, 45 U.S.L.W. 4049, 4050 (December 13, 1976), quoting *Jefferson* v. *Hackney*, 406 U.S. 535, 546-47 (1972).

And applying the end result test to the instant case, it is also clear that there has been no confiscation. The last approved reimbursement formula is cost-based, and operates to pick up periodically all proper inflationary cost increases.[27]

[27] The dissenting judge below was evidently confused by the various "hold-down" provisions of the Blue Cross-DVHC contract. Rates for the 1971-72 year could not exceed approximately 112% of the previous year's rates, but a hospital which exceeded its cost ceiling was permitted to cancel the contract on 15 days' notice (§ 18.4) (Ex. 171a-172a). *See also* Principle 1.4.7 (Ex. 198a-199a) and A.86 ¶ 29. The contract contemplated negotiation of a 1972-73 "hold-down", but the July 1, 1972 amendment recognized that controls under the Economic Stabilization Act had superseded most of the restrictions under the contract (Ex. no. 18) (Ex. 263a-265a). For 1972-73, intern and resident costs could not exceed 107% of the previous year's costs. Principle 1.4.7 (Ex. 198a-199a). The *Crozer-Chester* settlement recognized that by August 1974 all of these "hold-downs" had expired, and confirmed that "full reasonable costs" would be paid by Blue Cross (Ex. no. 23) (Ex. 288a ¶ 4). As indicated earlier, Blue Cross has the duty of fixing "interim" rates, and a misunderstanding arose when Blue Cross proceeded to exercise this power following the enactment of

(footnote continued on next page)

V: THE DISTRICT COURT WAS CORRECT IN CONCLUDING THAT THE ISSUE OF ALLEGED CONFISCATION COULD BE RESOLVED BY AN EXAMINATION OF THE COST-OF-SERVICE RATE FORMULA ITSELF, WITHOUT THE NEED FOR A TRIAL.

Appellants now assert that, even if their motion below for summary judgment was properly denied, nevertheless it was improper to have granted appellees' motion below for summary judgment. At a minimum, they now allege, the lower court should have required a trial of disputed issues of fact.

There is no occasion for remand of the instant case. No facts are in dispute. The only dispute revolves around the legal effect (*i.e.*, the constitutionality) of a rate formula that does not include reimbursement to hospitals for free care and other desired elements, of the establishment of a "stand by" mechanism for future contract disputes, and of the impact on these issues of the existence of an unlimited right of recoupment.

The dissenting judge below brought this remand issue to the attention of the District Court, as appellants note in their Jurisdictional Statements. A factual

Act No. 94. Ultimately an exchange of letters reaffirmed the fact that there was no fixed upper limit on the amount of "final" reimbursement (A.124-25 ¶¶ 72, 73). Ex. no. 40 (Ex. 441a-444a). At August 2, 1975 there was no fixed limit on the amount of reimbursement, interim or final, to which a DVHC hospital was entitled under the formula. Appellants in No. 75-1698 concede the point (J.S. at 8).

inquiry into alleged confiscatory effect conceivably could be appropriate if (as the dissenting judge thought) Act No. 94 set a fixed price unresponsive to inflationary pressures. However, as noted earlier, the statute is open-ended and automatically adjusts for inflation, and appellants have expressly conceded that the applicable Blue Cross-hospital contract as last amended provides for "full allowable costs with no ceiling upon a final accounting." J.S. in No. 75-1698 at 8.

The dispute here is analogous to a claim that a regulated industry has a constitutional right to a "fair value" as opposed to an "original cost" rate base. Cf. *Hope Natural Gas Co., supra.* It is the *formula* which is attacked, not a specific per diem rate for a specific hospital applicable during a specific period of time. Thus the request of the appellants for further hearing below or before a state agency is wholly inapposite, since the validity of the formula as an exercise of State legislative policy is a question of law.

VI: THE TERMS OF FINAL SETTLEMENT FOR ADMISSIONS TO THE APPELLANT HOSPITALS FOR THE PERIOD INCLUDED WITHIN THE AUGUST 15, 1974 TO AUGUST 2, 1975 REGULATORY HIATUS WERE NOT "VESTED" BEYOND THE REGULATORY POWER OF THE PENNSYLVANIA LEGISLATURE.

As discussed above, Act No. 94 imposes a 10 month (13 month) ratemaking scheme on appellant hospitals, prospectively beginning with the effective date of the

statute. In addition, Act No. 94 imposes the same ratemaking scheme on the hospital appellants in No. 75-1691 retroactively, for the 11½ month period preceding the statute (that is, for the period from the beginning of the "run-out" under the last preceding contract (August 15, 1974) to the effective date of the statute (August 2, 1975)).

In Part VII we will discuss in detail the considerations which have moved this Court to invalidate State action under the Contract Clause. But for our present purposes it is sufficient to note that the Clause does not stand in the way of State action which is prospective in nature, because the social interest sought to be preserved and advanced is an assurance that engagements entered into will be safe from later State action. The shorthand is to say that when the contract is closed the rights have "vested" and are beyond State power.

The only contract which appellants in No. 75-1691 can point to as allegedly impaired by Act No. 94 is the alleged subscriber-hospital contract for full "charges."[28] The subscriber is not before this Court objecting to Act No. 94, because it fulfilled his or her expectation that he or she would pay only $90 for an admission where the "charges" would be $1350.

[28] Although appellants at one point assert that the Pennsylvania legislature "breathed life into the terminated [Blue Cross-hospital] contract" (Brief in No. 75-1691 at 16), it is clear that there has been no legislative amendment of the termination clause of such contract.

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Moreover, the record clearly shows that the hospitals regarded this subscriber-hospital "contract" as highly provisional at best. Repeatedly and always in the past they have unilaterally and retroactively recharacterized admissions during inter-contract intervals, from subscriber-hospital "contracts" (producing $1350 in income) to Blue Cross-hospital admissions (producing $1080 in income) upon the execution of a succeeding Blue Cross-hospital contract (A.85 ¶ 27, A.86-87 ¶ 32, A.87 ¶34, A.90 ¶ 42). Indeed, both appellees and appellants have all along taken the position that whatever agreement is reached in the current contract negotiations will be made retroactive to the August 15, 1974 commencement of the run-out of the last contract between the parties, thereby substituting parties and changing the basis of payment.[29]

It is well established that regulated businesses may be required to enter into contracts with specified classes of customers. See, *e.g.*, 15 U.S.C. § 717f(a) (Natural Gas Act). Moreover, where a regulatory statute adopts by reference the terms of a private contract, those terms are incorporated into the statute and completely cease being a matter of contract. *Pennsylvania Water & Power Co., supra*, 343 U.S. at 421-22. That is, the General Assembly imposed a statute and not a contract on the hospitals. And it has been well established for more than half a century that private contracts fixing the charges to be collected by regulated businesses, even during their stated term, are regarded as entered into subject to the reserved authority in the State to modify the contract rate in the interest of the public welfare. *Union Dry Goods Co.* v. *Georgia Public Service Corp.*, 248 U.S. 372 (1919). See also Anno. 9 A. L. R. 1423 (1920).

[29] *See* letter from counsel for DVHC (Ex. no. 29). Thus the argument of appellants in No. 75-1691 that the typical Blue Cross sub-

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To return to the earlier hypothetical example, the hospitals were negotiating for a change in the cost formula which might increase the $120.00 per diem allowed cost to perhaps $123.60, but they had no expectation that they would receive precisely their retail charge ($150) or anything close to it. Thus, on August 1, 1974, immediately prior to the signing of Act No. 94, no hospital administrator knew who was going to pay the hospital for Blue Cross subscriber admissions for the prior 11½ months, nor could the administrator reasonably rely on receiving a $150 rate.

As the leading article on the subject suggests, "it has long been recognized that the term 'vested right' is conclusory–a right is vested when it has been so far perfected that it cannot be taken away by statute." C. Hochman, "The Supreme Court and the Constitutionality of Retroactive Legislation," 73 Harv. L. Rev. 692, 696 (1960). In the instant case, appellants cannot complain that the Pennsylvania legislature has impaired their "vested rights" to a specified payment level, since appellants themselves have acted to prevent the jelling of the identity of the parties and the rate of payment for Blue Cross subscriber admissions

scriber who renewed his coverage after July 31, 1974 in effect did so without justifiable expectation of coverage in a DVHC-represented hospital is obviously specious. The 2,400,000 members of the general public were entitled to assume, particularly in view of the enormous consequences of a shift to nonmember status, that the dispute would ultimately be settled retroactively—as it had always been before.

during the hiatus period which the statute seeks to correct.[30]

Thus, under recognized traditional principles of constitutional law, the retroactive aspect of Act No. 94 is well within the band of discretion granted State legislatures in economic matters.

VII: UNDER ESTABLISHED PRINCIPLES A STATE MAY EXTEND THE REACH OF ITS 10 MONTH (13 MONTH) TEMPORARY RATE PROCEDURES RETROACTIVELY FOR VARYING PERIODS UP TO 11½ MONTHS TO CLOSE A GAP IN REGULATION AND TO AVOID INVIDIOUS DISCRIMINATION AMONG BLUE CROSS SUBSCRIBERS.

It may be noted that the policy of Act No. 94 in its retroactive aspect (Parts VI and VII of this Brief) differs from the policy of the statute in its prospective (Parts II through V) and future aspects. That is, as to the 13 months following enactment of Act No. 94 and as to disputes under future contract terminations, the Pennsylvania legislature has sought to create a mechanism whereunder subscribers would not forego possibly vital hospital services out of fear of financial hardship. As to the 11½ months preceding enactment of the statute, on the other hand, this policy has no

[30] In *Murphy Nursing Home, supra*, rate action taken on June 25, 1969 and made retroactive to January 1, 1969 was held constitutional because the superseded rates were provisional or tentative rates, citing this Court's decision in *Great Northern Ry.* v. *Sunburst Oil & Ref. Co.*, 287 U.S. 358, 362 (1932).

application; that is, medical services have either been sought or foregone. Rather, the rationale for Act No. 94 in its retroactive element is the superficially inconsistent goals of relief from exorbitance in charges for hospitalization services and the strengthening of the cash-flow positions of the affected hospitals. For the reasons discussed in this Part VII, it is clear that the relief provided by retroactive application of Act No. 94 is constitutionally permissible.

A. Retroactivity is justifiable where it has been used to fill gaps in a regulatory system. *Fleming* v. *Rhodes*, 331 U.S. 100 (1947), involved an extension of the Emergency Price Control Act. After the original statute expired on June 30, 1946, several landlords obtained eviction orders in a State court without the certificates which the statute had required. Since the July 25, 1946 extension of the act had as its effective date June 30, the Price Administrator sought to enjoin the eviction of tenants under the State judgments. The District Court refused to enjoin the evictions, holding that the extension act violated the Constitution by retroactively invading vested rights of the landlords. On direct appeal, this Court reversed, stating: "Federal regulation of future action based upon rights previously acquired by the person regulated is not prohibited by the Constitution . . . The rights acquired by judgment have no different standing." 331 U.S. at 107.

It has been noted that "Although [the Court's] language is overly broad, the result is explainable by the strength of the public interest in not permitting a gap in the regulatory scheme and the fact that the extension of the act was certainly not totally unexpected." Hochman, *supra*, at 719. The same is true in the case at bar. The public interest in preventing gaps in price control schemes is at least as great in respect of health care as housing. And given the ferment in the Pennsylvania legislature for at least six years preceding Act No. 94 (see A.93 ¶ 54), the statutory plugging of the regulatory gap resulting from the failure of contract negotiations between the parties cannot be said to have been totally unexpected.

B. The retroactive feature of the legislation provides a well known reparations remedy. To the extent that Act No. 94 precludes appellant hospitals from collecting their full charges uncollected as of August 2, 1975 (*i.e.*, the effective date of the statute), it is valid under the rule of *Fleming* v. *Rhodes*. In addition, Act No. 94 requires appellant hospitals to disgorge "excess profits" collected prior to August 2, 1975. In this respect as well, the statute is fully justified under settled principles of regulatory law.

At common law, ratepayers had a right to be charged no more than a reasonable rate. Thus, an action for damages would lie where a carrier refused to receive goods offered for carriage except upon the

payment of an unreasonable sum. And an action to recover the excess over a reasonable rate would lie where in the absence of prior agreement as to price a carrier conditioned delivery of goods upon payment of an unreasonable exaction, or even where an exorbitant charge was stated on the receipt of the goods and coercively exacted either in advance or at the completion of the service. *Tex. & Pac. Ry. Co.* v. *Abilene Cotton Oil Co.*, 204 U.S. 426, 436 (1907); *Centre Cty. Lime Co.* v. *Pub. Serv. Com.*, 96 Pa. Super. 590, 602 (1929). Cf. *TIME, Inc.* v. *United States*, 359 U.S. 464, 472 n. 12 (1959) (questioning whether the common law right is to be free from undue discrimination rather than exorbitance).

The later right, to recover the excess over a reasonable rate, is, in ratemaking parlance, a right to "reparations". This right of ratepayers to reparations in respect of excessive company-made rates[31] provides something of a mirror image to the right of the company to recoupment in respect of inadequate agency-made temporary rates.

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[31] Administrative agencies may award reparation to ratepayers in respect of excessive company-made rates. Agency-made rates are not the subject of reparation. In the instant case, rates set unilaterally by the hospitals without reference to the last approved contract or Act No. 94 have the status, obviously, of company-made and not agency-made rates. See *Arizona Grocery Co.* v. *Atchison, T. & S.F. Ry. Co.*, 284 U.S. 370 (1932); *Pennsylvania R.R. Co.* v. *Pub. Serv. Com.*, 190 A.367, 371-72, 125 Pa. Super. 558, 567 (1937).

The common law right of ratepayers to reparations has been codified by both State and Federal statutes providing for reparation awards by administrative agencies. Under the Pennsylvania Public Utility Law, for example, regulated companies may be required to refund to a class of ratepayers any unjust or unreasonable portion of a rate paid within two years prior to a complaint. And under the Interstate Commerce Act, regulated companies may be compelled, by suit brought or complaint filed within two years from the time the cause of action accrues, to reimburse ratepayers in respect of unjust and unreasonable rates. 66 P.S. § 1153; 49 U.S.C. §§ 16(3) (railroads), 304a (motor carriers), 908 (water carriers), 1006a (freight forwarders).

To be sure, the legislative authority may vary or even abrogate the common law right to reparations. Thus, the Pennsylvania legislature, for example, has done away with the common law doctrine that a rate is unreasonable for reparation purposes only if extortionate or oppressive. And the Congress, on the other hand, has wholly abolished reparation rights in respect of rates subject to the Federal Power Act. *Pennsylvania R.R. Co.* v. *Pub. Serv. Com., supra*, 190 A. at 370, 125 Pa. Super. at 563; *Montana-Dakota Utilities Co.* v. *Northwestern Pub. Serv. Co.*, 341 U.S. 246 (1951).

Act No. 94 in its retrospective aspect, then, is a reparation statute. Like all such statutes, it reaches

backward to provide for the retrospective readjustment of rates set by the provider fixing the rates. Thus, it gives effect to the common law right of ratepayers to just and reasonable rates, and provides a remedial mechanism whereby ratepayers may enforce their claim to any excess over a reasonable rate.

Nor does Act No. 94 overreach in its attempt to protect ratepayers. The rates allowed are, as indicated above, not confiscatory. The 11½ month reparation period is not half as long as the time periods allowed by the above-noted Pennsylvania and Federal statutes. Since subscriber contracts were running out seriatim between August 15, 1974 and August 15, 1975, the retrospective effect is graduated and not total. And the retroactive feature is limited to hospitals which have benefited from the Blue Cross arrangement for at least 10 years (*i.e.*, its maximum impact on any hospital is limited to 11½ out of a 133-month or longer period).

Moreover, because of the effect of the run-out extremely discriminatory conditions would exist absent Act No. 94. A Blue Cross subscriber hospitalized in December 1974 whose subscriber contract anniversary was November 15 would pay $1100 for the very same services which the Blue Cross subscriber in the next bed whose subscriber contract anniversary was January 1 would pay only $90. It has long been recognized in this Court that elimination of discriminatory rate practices is a proper function of State police regulation. See, e.g., *Portland Ry. Light & Power*

Co. v. *Railroad Comm'n of Oregon*, 229 U.S. 397 (1913), and here the degree of discrimination was plainly invidious.

C. Nor does the regulatory scheme violate traditional, non-ratemaking principles of law. Even if the rate regulation cases are put to one side, the health delivery emergency triggered by the refusal of the DVHC hospitals to contract with Blue Cross clearly justified legislative intervention.

In this respect the relief afforded by Act No. 94 was to remove the impediment to the survival of the DVHC hospitals. Appellants' own evidence convincingly suggests that the hospitals live in a precarious cash flow situation (A.112-118). The Blue Cross-hospital contract recognized this fact with its provision for cash flow advances (Ex. No. 20, Ex. 276a-278a). The Pennsylvania legislature could properly take note of the fact that a population which had expected to pay $90 on a hospital discharge might not be in a position to pay $1350; that if even a substantial fraction of the Blue Cross subscriber patients discharged from DVHC hospitals during the run-out period could not or would not pay their bills the financial structure of the health delivery system in southeastern Pennsylvania would be significantly impaired;[32] and that retroactive rein-

[32] The legislature could surely take note of the fact that the hospitals were publicly claiming that without a 3% to 4% "plus factor" on Blue Cross business they would be in the most serious financial

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statement of the Blue Cross-DVHC contract would substitute a massive Blue Cross cash infusion into the hospitals for claims of uncertain collectability against a widely scattered group of patients.

Indeed, the record shows that within days after the enactment of Act No. 94, Blue Cross began to disburse large payments to the hospitals with respect to hiatus-period cases which retroactively became member hospitals admissions by virtue of the Act (A.55-59), thereby assuring the financial stability of the hospitals.

The leading case on the Contract Clause is *Home Bldg. & L. Assn.* v. *Blaisdell*, 290 U.S. 398 (1934). Indeed, in its most recent Contract Clause decision as of this writing[33], this Court recognized that *Blaisdell* amounts to "a comprehensive restatement of the prin-

difficulty; that during the 11½ month run-out approximately 50% of the Blue Cross-subscriber admissions were switched to a "self-pay" basis; that if even one-tenth of these were unable to pay their unexpectedly high hospital bills, approximately 5% of the hospitals' Blue Cross subscriber revenues would be cut off; and conclude that emergency relief was in order. Indeed, although the DVHC hospitals suggest in this Court (Brief in No. 75-1691 at 16) that Act No. 94 deprived them of a veritable bonanza in direct payments by Blue Cross subscribers, there is no record support for the proposition that the many claims against patients were generally collectible, and in point of fact the hospitals during the run-out period unsuccessfully brought suit against Blue Cross to break the non-assignment clause (Article VI, section 3; Ex. 91a-92a) of the Blue Cross-subscriber agreement in an attempt to shore up their cash flow. *Riddle Memorial Hospital et al.* v. *Blue Cross of Greater Philadelphia*, No. 75-1667 (Ct. Com. Pl. of Del. Cty., Pa.).

[33] Cf. *United States Trust Co. of New York* v. *New Jersey*, 134 N.J. Super. 124, 338 A.2d 833 (1975), *aff'd*, 69 N.J. 253, 353 A.2d 514 (1976), *prob. jur. noted*, 44 U.S.L.W. 3748 (1976).

ciples underlying the application of the Contract Clause." *El Paso* v. *Simmons*, 379 U.S. 497,508 (1965).

This Court began its analysis in *Blaisdell* by rejecting a literal approach to the Contract Clause. Not every impairment, it was held, is an impairment in the constitutional sense; literalism, Mr. Chief Justice Hughes stated, "would be better adapted to special pleadings" than to the construing of a Constitution. 290 U.S. at 428 (quoting *Ogden* v. *Saunders*, 12 Wheat. 213, 286). It is "beyond question", the Court held, "that the prohibition is not an absolute one and is not to be read with literal exactness like a mathematical formula." 290 U.S. at 428.[34] Rather, the true test under the Contract Clause is "whether the legislation is addressed to a legitimate end and the measures taken are reasonable and appropriate to that end." *Id.* at 438.

While emergency conditions do not create power, this Court stated, they may furnish the occasion for an exercise of power. And the declarations of emergency in respect of the law "cannot be regarded as a subterfuge or as lacking in adequate basis." *Id.* at 444. To meet these emergency conditions, there is a "necessary resid-

[34] The *Winnebago* case cited by the dissenting judge below misconceives the Contract Clause test and must accordingly be disregarded. Without ever citing a decision of this Court, *Winnebago* reaffirmed the theory of a South Carolina Supreme Court case that "any deviation from the terms of a contract [resulting from subsequent legislation] . . . (i)s an impairing of the obligation of the contract, however minute or apparently immaterial in effect." *Superior Motors, Inc.* v. *Winnebago Inds., Inc.*, 359 F. Supp. 773, 777-78 (D.S.C. 1973).

uum of state power"; "the State . . . continues to possess authority to safeguard the vital interests of its people . . . Not only are existing laws read into contracts in order to fix obligations as between the parties, but the reservation of essential attributes of soverign power is also read into contracts as a postulate of the legal order." *Id.* at 334, 335. That is, "the reservation of the reasonable exercise of the protective power of the State is read into all contracts," and such reserved power may be exercised to meet emergency conditions resulting from economic distress. *Id.* at 444.

If such an emergency makes legislation appropriate, the legislation must also be reasonable in its terms in light of the conditions prevailing.[35] That this Court

[35] Act No. 95 is clearly a reasonable measure since it is limited in time (*i.e.*, to 11½ months), coverage (*i.e.*, to hospitals having benefited substantially continuously for at least 10 years from the system of guaranteed payments policed by the Commonwealth), extent (*i.e.*, most costs are reimbursed, with only free care and other disputed items omitted in reliance on the American Hospital Association-based Medicare formula), effect (any settlement reached by the parties is made effective as of August 15, 1974), and scope (most disputed claims having been settled by accord and satisfaction) (see A.49-65). Thus, the *Kavanaugh* and *Radford* cases cited by appellants are inapposite.

The statute in *Kavanaugh* "cut down the security of a mortgage without moderation or reason [and] in a spirit of oppression". In enacting the statute, the Arkansas legislature "put restraint aside [and acted] with studied indifference to the interests of the mortgagee." Limitations as to "reasonable time" and "compliance . . . with reasonable conditions" were wholly lacking from the statute. *W. B. Worthen Co.* v. *Kavanaugh*, 295 U.S. 56, 60, 61 (1935). *Radford* similarly involved a statute which unreasonably promoted

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might strike a different balance is, of course, beside the point so long as the legislature has not been arbitrary: "Whether the legislation is wise or unwise as a matter of policy is a question with which we are not concerned." *Id.* at 447-48. That is, as this Court reaffirmed in *El Paso*, "The State has the 'soverign right . . . to protect the . . . general welfare of the people . . . Once we are in this domain of the reserve power of a State we must respect the wide discretion on the part of the legislature in determining what is and what is not necessary.'" 379 U.S. at 508-09 (quoting *East New York Savings Bank* v. *Hahn*, 326 U.S. 230, 232-33). In the instant case, the judgment to prefer the immediate and certain cash flow of the reinstated Blue Cross funding for the hope of collections from an unprepared citizenry was peculiarly a legislative determination.

Under the *Blaisdell* legitimate end-appropriate and reasonable means test, it is clear that Act No. 94 is constitutionally permissible.[36] With the financial via-

the interests of mortgagors at the expense of mortgagees. *Louisville Joint Stock Land Bank* v. *Radford*, 295 U.S. 555 (1935) (invalidating the first Frazier-Lemke Act). Compare *Wright* v. *Vinton Branch of the Mountain Trust Bank*, 300 U.S. 440 (1937) (sustaining the revised Frazier-Lemke Act). See also *W. B. Worthen Co.* v. *Thomas*, 292 U.S. 426, 434 (1934) (invalidating an Arkansas statute that "contains no limitations as to time, amount, circumstances, or need").

[36] Appellants variously assert other Contract Clause tests which depart radically from the existing standard. Thus, appellants would strike down Act No. 94 as impairing contractual substance as con-

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bility in the balance of hospitals representing approximately one-half of the nonprofit charitable beds served by Blue Cross of Greater Philadelphia[37], the statute was clearly "addressed to a legitimate end, that is, the legislation was not for the mere advantage of particular individuals but for the protection of a basic interest of society." *Blaisdell*, *supra*, 290 U.S. at 445.

D. Indeed, the Act No. 94 approach is appropriate precisely because it avoids impairing the obligation of Blue Cross-subscriber contracts.

Under the Blue Cross-subscriber contracts, Blue Cross obligates itself to pay allowable costs to hospitals in respect of subscriber admissions to member hospitals, but only the much lower indemnity payments to subscribers in respect of subscriber admissions to nonmember hospitals. Thus, in the absence of Act No. 94,

trasted with remedy (Brief in No. 75-1691 at 23); yet it is clear that "the right-remedy dichotomy is conclusory only, and therefore of little use in deciding a particular case." Hochman, *supra*, at 711-12n. 106. Accord, *Wright* v. *Vinton Branch*, *supra*, 300 U.S. at 470 (Brandeis, J.). Similarly, appellants suggest that legislation may sensibly be assessed without regard to "how great the public need may be", and that the sole test is "the degree of deprivation involved." Brief in No. 75-1691 at 19, 23.

[37] The hospitals on behalf of which the DVHC negotiates have split into two groups. The hospitals represented by the DVHC in this litigation represent in the aggregate approximately one-half of the nonprofit charitable beds served by appellee Blue Cross of Greater Philadelphia. The remaining beds are represented by the seven local medical school hospitals and certain other hospitals which, although represented by DVHC in negotiations, voluntarily settled their dispute with Blue Cross (A.89-90 ¶¶ 40-42).

Blue Cross would only have been obligated to pay the generally lower indemnity benefits for DVHC hospital admissions of ill subscribers. Accordingly, healthy subscribers would have received a windfall, since the reserves of the Plan would have swelled in an amount equal to the excess of the cost of service benefits over the cost indemnity benefits (*i.e.*, $990 service benefit — $250 indemnity benefit = $740 per case reserve augmentation).

Had the General Assembly simply "unlocked" the reserves of the Plan (for example, by enacting that indemnity benefits during the hiatus period should be $150 a day but not more than the hospitals' retail "charges") to provide a needed cash infusion to the DVHC hospitals, healthy subscribers could well have alleged an impairment of their contractual right to have Blue Cross reserves used only to make the payments described in their subscriber contracts, where they would be accompanied by the significant cost controls described earlier. By "reinstating" the Blue Cross-hospital contracts with appellants in No. 75-1691, on the other hand, Act No. 94 allows service benefits to be paid to appellant hospitals in accordance with the terms of the separate Blue Cross-subscriber contracts.

Indeed, if there is any possible defect in the "reinstatement" characterization utilized in Act No. 94, it is the healthy Blue Cross subscribers and not the hospitals who are thereby aggrieved, and those subscribers are not before this Court.

CONCLUSION

For the reasons discussed above, the judgment of the District Court should be affirmed.

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ANNEX A

Part 1: History of Hospital Regulation In Pennsylvania

Originally hospitals were created in Pennsylvania by special act. Thus the act of May 11, 1751, 5 Pa. Stat. 128, 1 Sm. L. 208, which created the Pennsylvania Hospital, expressly declared providing hospitalization to be a "work of public service." The "laws, rules and orders" of the Hospital were made expressly subject to regulation by the Chief Justice, the Speaker of the Assembly and the Attorney General. § 1.

An appropriation of public funds was made to the hospital (§ 2), and its books and records were made subject to audit by visitors appointed by the General Assembly (§ 4). This hospital was thereafter regulated by a succession of detailed acts. *See, e.g.*, act of April 11, 1793, 3 Sm. L. 117.

Hospitals could be and were incorporated under the Corporation Act of 1791, act of April 6, 1791, 3 Sm. L. 20, 14 Pa. Stat. 50, which was a general statute for the incorporation of charitable corporations. Hospital incorporations under this act were scrutinized by the Attorney General and the Supreme Court. Ultimately, by the act of October 13, 1840 (1841 P.L. 1), the reviewing function passed to the courts of common pleas.

By the act of July 17, 1917 (P.L. 1120), any charter application or amendment submitted by any hospital "in which indigent persons are to be treated, or to be treated or maintained, in whole or in part, at public expense" was required to be submitted to the Board of

Public Charities for its opinion as to such matters as whether the needs of the community wherein the hospital was to be located required the incorporation of the hospital.

The act of June 20, 1919 (P.L. 505) (10 P.S. §§ 1-3) requires the approval by the Board of Public Charities (now Department of Public Welfare) of the plans of any private hospital or other private charitable institution as a prerequisite for eligibility for State aid.

The Nonprofit Corporation Law of 1933, act of May 5, 1933 (P.L. 289), §§ 212, 707 and 807 made a favorable finding by the Department of Welfare a prerequisite to incorporation and actions of certain hospitals. These provisions now appear in 67 Pa.C.S.A. §§ 6102 and 6103.

The Pennsylvania Hospital Survey and Construction Act, act of July 5, 1947 (P.L. 1335), provided for a review function and state planning of hospital construction, including the setting of minimum standards for maintenance and operation. This authority was transferred to The Administrative Code of 1929, act of April 9, 1929 (P.L. 177), § 2305.1 and is now Public Welfare Code, act of June 13, 1967 (P.L. 31, No. 21), § 201(c) (62 P.S. § 201(c)).

Proprietary (*i.e.*, profit-making) hospitals were subjected to licensing by the act of June 12, 1931 (P.L. 510). This act was briefly superseded by the act of February 2, 1966 (1965 P.L. 1881) and the provision is now found in the Public Welfare Code, §§ 1001 et seq. (62 P.S. § 1001 et seq.).

Bills to impose direct economic regulation on hospitals have been pending in the General Assembly at least since 1969 (A.93 ¶ 54).

Part 2: Other State Regulation

Alaska Stat. § 21.87.180, Fla. Stat. § 641.03, Code of Ga. § 56-1711, Idaho Code § 41-3416, Ill. Stat. § 32:555, Iowa Code § 514.8, Code of Md. § 48A:356, L. Mass. §§ 176A:5, 6A:32, Mich. Comp. L. § 550.503, Rev. Stat. of Neb. § 21-1512, N. Dak. Cent. Code § 26-26-09, Ohio Rev. Code § 1739.051, S. Dak. Comp. L. § 58-40-12, Tenn. Code § 56-3014, Tex. Ins. Code § 20.15.

See also Code of Ala. § 28-311, Ariz. Rev. Stat. § 20-830, Ark. Stat. § 66-4908, Calif. Ins. Code § 11510, Colo. Rev. Stat. § 10-16-130, Conn. Gen. Stat. § 33-166, Del. Code § 18-6306, Hawaii Rev. Stat. § 393-1, Ind. Stat. § 27-8-6-1, Kan. Stat. § 40-1806, Ky. Rev. Stat. § 304.32-130, La. Rev. Stat. § 22:659, Maine Rev. Stat. § 24-2316, Minn. Stat. § 62C. 16, Miss. Code § 83-41-123, Rev. Code of Mont. § 15-2304, Mo. Stat. § 354.085, Nev. Rev. Stat. § 695 B. 140, N.H. Rev. Stat. § 419:6, N. Mex. Stat. § 58-25-17, Gen. Stat. of N. Car. § 57-4, Okla. Stat. § 36-2606, Ore. Rev. Stat. § 750.005, L. of R.I. §§ 29-19-7, 14, Code of L. of S. Car. § 37-441, Utah Code § 31-37-16, Vt. Stat. § 4513, Code of Va. § 32-195.1, Rev. Code of

Annex A

Wash. § 48.44.070, W. Va. Code § 33-24-6, Wis. Stat. § 182.032, Wyo. Stat. § 26.1-453.1.

See also N.J. Stat. §§ 17:48-7, 26:2H-18, N.Y. Ins. Law § 252, Public Health Law § 2807.

Part 3: Federal Regulation

Hospitals providing Federal Medicare benefits are subject to economic regulation *pro tanto*, and may be reimbursed only for "the reasonable cost of such services." *See generally* 20 C.F.R. § 405.401 et seq.

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